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SEPTEMBER, 1956

Help for the Hopeless
. . . One of the First Panel Discussions Ever Presented on the Subject.

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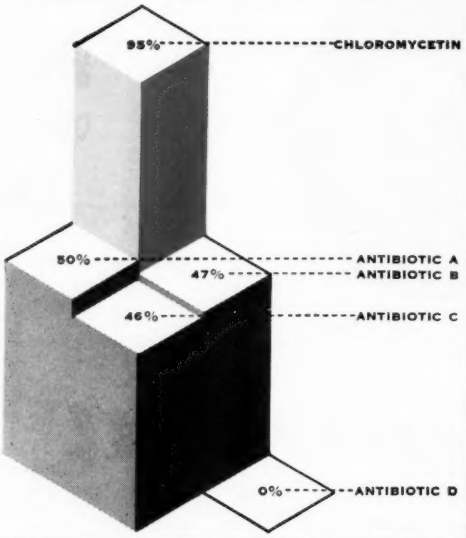

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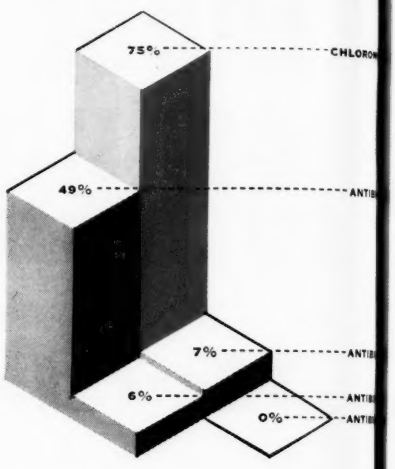

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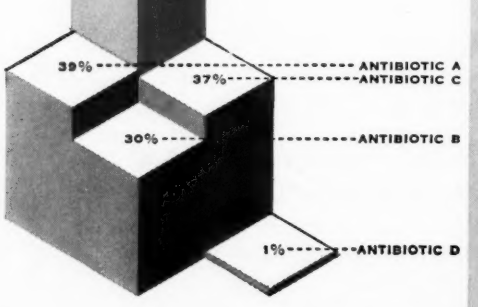

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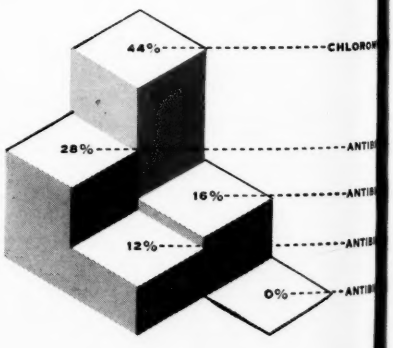

*This graph, based on *in vitro*
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THE DOOMED INFANT AND CHILD

CLEMENT A. SMITH, M.D., Associate Professor of Pediatrics, Boston Lying-In Hospital, and Harvard Medical School; Chief, Infants' Division, Children's Hospital, Boston, Massachusetts

THIS IS UNDOUBTEDLY a more interesting subject to most doctors than you would think from the scarcity of papers appearing in the literature on these aspects of medical practice. Certainly questions of how one comforts and supports parents of children with fatal illnesses or infants with irremediable congenital malformations are of interest to medical students, who consider that they get too little instruction in these aspects of medicine.

Of course, the main aspect of the doctor's work is not telling people bad news and helping them through it. We should not, I suppose, pay too much attention to these things and neglect matters of careful diagnosis and treatment which should reduce the occasions when sympathy is needed. I remember a book in which a sentimental lady said that Doctor So-and-so was such a nice family doctor "because he was always so good with the relatives—afterwards." This is a good attribute for the doctor to have, but of course not one which he should be using much of the time.

Nevertheless, it is a welcome and an unusual opportunity to participate in a discussion of these problems. I might say that Dr. Clark wrote the title of my small portion and I don't know that I would have selected the word "doomed" to describe the occasional child who seemingly cannot recover. I would certainly use the terms "doomed" and "hopeless" with many mental quotation marks and reservations. Not many infants are "doomed" these days. There are so many fewer "hopeless" situations than there used to be, and one never knows which disease will yield next.

We have all had, no doubt, some experiences of the sort that occurred to me when I was a rotating intern on the medical service in Ann Arbor in the late 1920's. I wish this concerned babies or children, but it happened to have involved people at the other end of life. One of my jobs on the medical ward was to transfuse four old men who had pernicious anemia. I didn't like the job. The men didn't want to be transfused every few days. Every one agreed that they were going to die. It seemed silly for me to be making life longer and painful for them, but they were alive when I came on the service and they were alive when I left it. I wasn't aware at the time that this was any more than the usual intern's job, but a few months later I dropped into that ward, missed the four old men who had pernicious anemia, and asked the new intern what happened to them, supposing they had all died. The intern said: "No. Something surprising happened. A man in Boston named Minot published something about feeding people with pernicious anemia on liver, and so we tried it a few days after you left; and they have all gone home in what looks like a remission."

Such an experience should happen to every young doctor. He would never again be quite willing to let go of anybody as "doomed."

Not only are states of doom in young infants becoming increasingly rare; infancy and childhood have always been times when the unavoidable doom faced by everyone is a long time away. Anyone over fifty gets almost perceptibly nearer some sort of doom all the time, and when the patient is sixty or seventy, the disease for which you are treating him may be prevented from being fatal, but something that will be fatal is not so far ahead. If the child gets over what is the matter with him, then he has a lifetime before natural causes overtake him.

Therefore, on several principles, I would begin with the idea that we resist acceptance of doom and hopelessness in the care of pediatric patients. Of

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*A forum presented at the Annual Meeting of the Rhode Island Chapter, American Academy of General Practice, at the Rhode Island Medical Society Library, Providence, on May 1, 1956.

course, we know there are children with leukemia and with other forms of malignancies, and there are children with chronic, progressive nephritis or with the increasingly rare kinds of congenital abnormalities which cannot yet be dealt with by the surgeon. We have to face such problems; and when we do, we must deal with the child and with his relatives.

I don't think you deal with the child at all under these circumstances, except to be nice to him and make him comfortable and be his friend. You certainly don't say anything to him about the fact that he isn't going to get well.

I once accepted an invitation to discuss the doctor's work with a group of young theological students, one of whom astonished me by asking:

"How do you tell a child that he is going to die?"

It never occurred to me to do so, and I never have done so. If a child is doomed to something less than death but rather sudden and devastating in its consequences like losing a leg by amputation, I would favor telling him about it beforehand, gently, and without too much fuss. It would be an unforgivable injury to a child to discover when he awoke from the anesthesia that his leg was gone and that we didn't think he should know about it beforehand. If he is young enough not to be hurt by not being told, all right; but if he is old enough to be hurt more by the surprise and shock than by being told, then he ought to be told; and there are ways of doing such things calmly but not brutally, which do not hurt too much. Anything you do under such a situation hurts. I think we should get away from the idea that with children we must somehow soften blows in a special way. Blows cannot be always softened; but by explanation and sharing, their impact may be made somewhat less concentrated and acute.

Telling the Parents

So much, then, for dealing with the child himself.

Now, as far as the parents go, the handling of the child with a fatal disease is, of course, difficult, but it has some relieving elements of hope about it as compared to telling an adult of his own approaching death or that of a husband or wife. Most parents, fortunately, have another child or will have more in the future. Though the parents should not be reminded of this fact directly, it is usually there as a consolation in the background. Some parents know they may have only the one; then it is much harder.

When one is as sure as he can be that a child's illness is presumably fatal, I don't think he has any right to keep the parents in the dark. He must honestly tell them what is going to happen, but always in an individual way.

Then there arises the problem of how much effort, pain, and parental expense should go into making a fight for the child's life. Some people would rather you didn't do as much as others would. These are the sentimental parents who really can take a great deal of comfort, when they know what to expect, by saying:

"God gave him to us, and is taking him back again; why interfere?"

Once people feel that way, it is a great help to know it, because they really would rather take the child home from the hospital than to have the last transfusion or X-ray treatment or laparotomy. However, there are other more intellectual and compulsive fathers and mothers who cannot stand the idea that everything has not been done, and will carry their guilt feelings all their lives, if they believe any hope has gone untried.

We are fortunate in having the Jimmy Fund Building and the Children's Cancer Research group in Boston. From seeing some children cared for by that institution, I know that they provide a superb grade of help, therapy and pain relief for all of the various malignant diseases of young children. Doctor Farber's group have the knowledge of how and what to tell parents; they also know by great experience which patients justify the most intensive treatment.

As an example of the value of this Tumor Therapy Service, a friend of mine who used to be one of our Residents telephoned me recently from his home in Virginia; his three-weeks'-old baby had been diagnosed as having acute leukemia, and he asked whether he should bring the baby to Boston. I couldn't make that decision without asking Doctor Farber, who advised leaving this infant with rapidly advancing malignant disease where he was, since nothing could be gained by moving him. I called the baby's father who said:

"That's all I wanted to know."

I'm sure he meant it. The expert can be helpful by preventing unnecessary anguish, just as in other situations he may properly and equally helpfully advise an active program of therapy.

Perhaps a harder job than the management of a fatal or presumably fatal illness arises from the non-fatal disease or mental retardation because of which the child is going to be obviously abnormal and a sorrow to the family, but is not going to die.

This we meet most commonly at the Lying-In Hospital when a mother gives birth to an infant with an irreparable malformation. The classic case is that of Mongolism, in which the death, on the one hand, or normal development on the other, are almost equally unlikely.

We find there are two schools of thought about what should be done. Many of the staff—perhaps most of the obstetricians—feel that the thing to do is to send the child away, without the mother

ever seeing it, by placement in some sort of institution. The argument is that his existence will easily be forgotten, indeed that he never had existed in the eyes of the mother.

There is another group, to which I belong, who do not think that such handling is good, except perhaps in a few unusual instances. Certainly no one type of handling is universally useful. But I feel that if we are good enough doctors to deal with people at all, then we can help them to understand a Mongolian child, know his limitations by having him in the family for a little while and thus see why he should be cared for elsewhere. Of course they will get attached to him; and his departure will be a wound. But at least it will not be so traumatic as the thought that the mother has produced something too horrible for any of them to see, and they won't, for the rest of their lives, be thinking "I wonder what the child was like who never came home."

I don't think that life lets you get out of such things so easily, or that parents really do get away from the pain of such a disappointment. They will not forget the matter by concealment of the baby, nor will the blow to the mother be softened by pretending that it isn't there because she has no baby. Tragedy or sorrow has somehow to be processed by working with it—or through it. And a large part of the doctor's job is to help the parents to do that.

There are a few among the intellectuals who feel it such a shameful thing to have produced a mentally subnormal child that they cannot bear the fact of the child's presence; they should at least be told that they have the alternative of placing the infant at once and that he need not come home at all. If they would rather do that, then I would help them to do it. At the other extreme, there are simple people, like the woman who brought her child to me from a little town in a neighboring state because her doctor said:

"I have tried and tried to persuade Mrs. So-and-so that her baby is a Mongol, but I cannot, so I am sending her down to you."

On the face of it, I think there is apt to be something wrong when a physician feels he must persuade parents to accept bad news. The child had obvious Mongolian features and was obviously retarded for her age of two and one-half years. But her mother and her four-year-old sister thought she was charming. Her mother said the father thought so, too.

I told her I thought the child would develop slowly and would never get very far in school, but that if they wanted to give her home care, they certainly should do so. The mother was grateful. While leaving the office and inquiring how to get to North Station, she mentioned her amazement at the size of the city. It turned out that she had once been in Portland, but never in any bigger city.

I believe that in this woman's relatively simple civilization, this two-year-old child will be a source of comfort and a recipient of good care. Nobody is worrying the parents over the child's adequacy. Probably many families in that village have their odd child at home; why try to send this one away? A woman with that degree of resilience and trust will not have her life ruined by having such a child around.

And there are all degrees between these extremes.

I think the Mongol (or otherwise defective) child should not go home from the hospital on the parents' understanding that you are sending it home as a good child. It is not fair to them for you to avoid the issue in that way. Neither is it possible for you to think you can tell the father about it, so that the mother will not know.

That never works. The mother knows that something is wrong; and that divides the father from the mother, and the family solidarity which you are trying to promote, falls apart. You have to tell them. You tell them that you don't think this child is going to do well and that you feel the child will have the best chance to show what he can do, and they will have the best chance to learn something about him, if they take him home while you work out a plan with them. You also point out, incidentally, that this is a very common thing and that they are members of a very big fraternity. They will be surprised and comforted to find out how big the group is of people all around them who are sharing the same problems.

After that, your job is to help them obtain a reasonably factual opinion of the child. One need not go out of his way to point out the abnormalities. But when the baby is brought for a physical examination or a diphtheria shot I don't think the doctor should say:

"My, but isn't he strong!", or "Hasn't he a cunning smile!"

The neighbors may do that, in trying to make it less difficult, but I do not think that the doctor should allow himself to encourage the parents by concealing the facts of the problem.

Perhaps the burden of my ideas is that there are no routines; there are only principles—of honesty, gentleness, and firmness in facing a common situation which countless mothers and fathers have faced before.

Finally, I might say something in regard to a statement made by Doctor Clark in his opening remarks. He pointed out that in excusing himself from getting involved in these matters, the doctors should not say:

"Why should I take these people's money for nothing?"

The doctor is contributing something. He is shar-

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ing in a painful situation. He is making a plan. He is helping people to work through that plan. He is often providing a good deal more than he might by prescribing penicillin or even by removing a uterine fibroid. Not that he should charge accordingly, but at least he should not feel that his services are for nothing. He is there to help and he should be able to help greatly.

HE WAS IN THE PRIME OF LIFE

EARLE M. CHAPMAN, M.D., Assistant Clinical Professor of Medicine, Harvard Medical School; Physician, Massachusetts General Hospital, Boston, Massachusetts

It is an unusual occasion today that we are all here. I understand that this is the first time this group has met with the Rhode Island Medical Society, and I think this is one of the first such programs. There is some occasional writing on the subject, but I have not heard of such a program before, and certainly I have not taken part in such a program previous to this time.

Usually, when I talk, it is on thyroid disease, my specialty, which takes only about 30 per cent of my time. My experience then in general practice comprises the background for the present remarks.

I should like to be able to talk as informally and as interestingly as Doctor Smith did, but I have a few notes here on the subject to which I shall refer in order to keep closer to the line of thinking.

Coming back to the title of my part of this afternoon's program, *He was in the Prime of Life* this leads, first, to a definition of this period of a man's life, and being over fifty, I am going to choose the years from thirty to sixty as those usually the most active and creative in man's activity. This gives me a wide range to cover.

When an illness that appears to be hopeless fastens on to a man in this age group, what should the doctor do about it?

What he *can* do, and what he *should* do, and what he *actually does* become a blend of ethics, socio-economic leverage, and emotional reactions of the physician in his relation with that particular patient.

As Doctor Smith has said, there is no one answer or fixed pattern to cover our behavior under these circumstances. We might, at the outset, cite five examples that are so typical of medical practice that I would venture to say that each one of you in general practice now has at least one such case under your care:

1. The sixty-year-old man with relentless congestive heart failure.
2. The fifty-year-old business executive with Hodgkin's disease and severe anemia.
3. The forty-year-old worker with chronic nephritis and a slowly deepening uremia.
4. The forty-year-old mother of three maturing children who has "arthritis" from metastatic carcinoma from a breast operation four years previously when she was told that it was a cyst.
5. The thirty-year-old man newly married and found to have leukemia.

What to say?

What to do?

Our first duty, it seems, is to our patient, and next, it is to the family, and lastly it is to society as a whole.

I should like to discuss these three aspects, the patient, the family, and society as a whole.

The burden of decision, of course, and responsibility must rest with the physician who accepts the care of this patient. Once having accepted the situation, he is committed, to do his very best to follow this through. I think that often it is forgotten that we, as physicians, have the right to reject or accept. Often times the emotional troubles and problems we get into lie in accepting the responsibility when, at the outset, as the Chinese would say:

"This is the kind of a case with which I feel I am not qualified to cope. I advise that you seek and obtain another physician to handle the matter."

Too often, we do not employ this technique. Although the task may be distasteful and difficult, it usually can be managed with patience and the revelations of time to those concerned.

First off, it is important, I think, to point out, as Doctor Smith did, about this term "hopeless." It is a term that we use, and we apply this in our knowledge of the situation, but certainly it is not the term to use before the patient or even the patient's family because I think that we should never deny some hope. We never know just what is around the corner, and when I heard you tell the story about Doctor George Minot, I was afraid you were going to steal my thunder because I had the same analogy. It was about Doctor Minot's personal life.

You will recall that Doctor Minot was very ill with diabetes; this was in the early 1920's and before he had discovered that liver extracts and liver cure pernicious anemia. Just then came insulin, which rescued his life for his great contribution to medicine, and his winning of the Nobel Prize.

When insulin did this, no one could have predicted the moment it was going to happen. I am sure that he was treated by wise physicians who took a hopeful attitude, although he was a severe diabetic at that time.

The behavior of the physician is most important. I do not want to be pedantic, but repetition of even

prayers seems helpful, so I would like to repeat the commonplaces that are sometimes forgotten in the busy day's work, in the practice of medicine.

It is hard enough for relatives or friends to visit the hopeless, and it is even harder for the physicians, because he enters presumably to cure illness and to save life. But here, he has recognized defeat in the living person; it is only a matter of time—when—according to his best diagnostic methods. How long will it go on? He can't tell how long it is going to be, but he can take a shrewd, clinical guess. That always leaves this element of hope remaining. Some physicians cannot accept this defeat and avoid seeing the patient. I wonder if that would not be the point where it could be suggested that another physician be employed, with the physician admitting that he just cannot take it, and that he isn't built to do it. Perhaps the physician should face it honestly and say:

"Can't you find somebody else who has the right temperament?"

And frankly, maybe the minister could do as well, with his ministerial calmness and simple words and phrases, bringing spiritual strength to this patient. Perhaps we do not often enough call upon the ministers.

For the average man who does his duty, he has found that words of pity are out of place, that sugary tidings turn rancid, and that a casual or airy attitude that attempts to dismiss all thought of danger only disgusts the patient. The friendly, direct approach, with natural voice and acts are best received. Many patients admire the physician who says little, but by his strong, firm manner and a gentle touch of the hand conveys the deep companionship of man.

Nothing but the Truth?

The starting point, then, of the professional care comes with—"Shall you tell the adult patient the truth?"

For years and years, the usual course has been for the family to ask the physician to deny that anything is seriously wrong and to maintain that there is nothing to worry about. This is, instinctively, the first reaction of the family. Too often the physician has fallen into this trap and agreed, perhaps because in some college course he was trained to do this, and also because he was so busy learning the patterns of disease in medical school and during his intern years that he did not receive any teaching or preceptor training in these subtleties or in the art of the practice of medicine.

I think that we can criticize our medical schools for being lax in this area of teaching. I am not aware of such teaching coming to the medical students of Harvard, except by contact with the physicians during the last year of school on the wards and during bedside care. Too often, this is pushed to the Senior on the job; the Visiting Man is too busy overseeing the whole program.

This year, we did meet with our students, and we had a talk covering this very area, and I think it marks a real advance in this problem that we have to face.

The patient who feels himself slipping in health and strength, or who, after diagnostic procedures that may include surgical exploration, finds himself returning for prolonged X-ray treatments or frequent visits with the doctor, can hardly be so stupid as to believe such naiveté on the part of the doctor or the family that everything is "all right" and that he is going to get well, and don't worry about that, or we will talk about that next time. His wife may be irritable and break down and cry easily, and he knows that she has been given bad news. His business partner may come in and ask such pointed questions about future management that the patient has little doubt of the gravity of his illness.

But Doctor Cheerful forces a smile, slaps the back and utters nonsense while he avoids looking the patient squarely in the eye.

Doctor Richard Cabot rocked the medical profession a half century ago when he began to tell the patients the truth, especially about cancer. The debate has been bitter but gradually the affirmatives have won a majority.

In 1953, Otis R. Bowen of Indiana conducted a survey of 500 of his patients to determine if they desired to know whether or not they had a cancer. So far as I know, this is one of few scientific approaches to the problem, which obviously has a great impact. He was surprised to find a large majority of his patients felt that the patient could not be fooled and they desired to know whether or not they had a cancer, and many of them desired that their families should know. Many even expressed a desire to have co-operation between their physician, their minister and close relatives in handling the situation.

One interesting point was that the age group up to thirty-five expressed greater trust and confidence in their physician than did the older age groups. To me, the inference is clear; the older people had too often found doctors lying; they had lost faith in physicians through experiences. Never before have we as physicians such need to maintain or restore faith in our behavior.

I believe the "hopeless" patients have the right to know enough of the truth to so order the balance of their lives remaining that they can be filled out with dignity and to the best advantage of the whole family.

My belief is that honesty is best; the truth should usually be told, but individual tact avoids saying the unnecessary, or too much.

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Now, let us deal with the family. Many times, I have seen a peace and satisfaction come over a family united in the truth, when previously there had been outbursts of pent-up emotions, much sidling out the door to talk to the doctor alone, and evasive answers to direct questions.

Evasive tactics instill suspicion and poison the mind. Let us take the first example of the sixty-year-old person with congestive heart failure; he may be hopeless if he has lost the desire to live. If he has a burning desire to live, and a usefulness, then by sticking religiously to a form of treatment he may live on for many years. He needs the frequent advice and encouragement of his doctor. The day may come when he is tired of it all and says:

"What's the use of this struggling? Why not let Nature take its course?"

What can the physician say? It is a tough situation and it puts you on the spot. The physician has but one answer, and he can help the patient; sometimes the best argument against such passive suicide is that the sick one is needed and loved by some one in the family, some one whom he should not desert.

The family as a future has to be considered. I have just finished two months of visiting on the wards of the Massachusetts General Hospital, and in this time have seen patients coming back to our Service because they seemed to be unable to find the support of a wise generalist in medicine.

J. A. had relentless Bright's disease, and with crises of hypertension and uremia, he would demand to be brought back to our hospital. Here, the eager House Staff made heroic efforts to prolong his life. Each time the electrolyte pattern was restored, and he miraculously went home to have death take another little bite out of him. Finally, on his sixth return, he died. The family received a total bill of $1,960.00. He had sacrificed the education of the eldest son. Joe didn't mean to do it. A good family doctor would have avoided this wasteful hospitalization.

In retrospect, I believe our Social Service should have found a sympathetic general practitioner who could have relieved Joe's anxiety and organized his personality, to make him live comfortably but more effectively for his family.

No one could cure him. The physician in such a case consults with the family first. They may say:

"Spare no expense; keep our Joe living."

But that is an emotional response that is given, often without reference to financial reality. The physician must weigh the facts carefully and make the decision that he deems correct, but one that will spare the family a later sense of guilt.

Denying the heroic or the ridiculous, is often part of the doctor's job. But, an equally important job is to convince the family that all possible methods of reasonable medical practice have been applied in his case. When the final day arrives, the family must not suffer the belief that they have failed a loved one, but rather that they have done all that could be done. It requires patience and careful explanation.

One valid criticism of the general practitioner in such cases is heard from the family who complain that "he is too busy." They want to talk things over, but they find that their doctor is either hand-in-hand, backing toward the door to make his next call as if the next case could possibly be more important than the life there in the balance, or they go to the office, but find the place so crowded and so hurried that adequate explanations seem impossible.

Then comes their next logical step:

"Well, doctor, should we take him to *X* Clinic or call a specialist?"

The reactions of the generalist to this are varied. At first, men are angered because their attempted explanations have failed. Another response is to become sulky because he feels that the family doubt his medical competence or judgment. That, to me, is truly an unfortunate attitude for any physician to assume. The civil courts have long assumed that it takes twelve men or a superior Judge to pass judgment on even much lighter matters than the very continuation of a person's life. A well-chosen, single consultant or a brief period in the hospital, including consultation may only give supportive evidence to what you already knew, but it tempers the icy thoughts within the family and makes future management easier. Again, you have treated the anxiety of the family or the patient, a treatable condition, when the disease itself is untreatable. This, too, is the doctor's job.

And now, we come to the relation of the patient to society as a whole. A question we must face is:

"Is physiologic life sacrosanct?"

But, as my friend, Barney Crile, has questioned:

"When do we save one-half a life?"

There is no answer to this question, for it is deeply imbedded in a fluid medium of shifting emotional reactions of both patient and physician. This medium has a congealing point, slightly below religious heat, and a melting point that cannot escape the blasts of pseudo-scientists in search of personal fame and another paper.

Medical quackery is no longer practiced by kerosene light off the tail end of a wagon; it is sometimes clothed in grants of money and takes place in the scientific aura of some otherwise honest institution.

The surgical attacks on disease have produced brilliant results in our time, and we have seen hopeless cardiacs restored to work; we have seen lung cancers removed; we have seen vascular systems

repaired, and we have watched the brain pierced with percentile improvements. But, now and then this enthusiasm to destroy disease has led to such mutilation of the person and a consequent dependency on society that I cannot assign it to an ethical place in medical practice.

I have in mind a forty-five-year-old man on our ward, who had an extensive cancer of the jaw, who was operated upon and then heavily radiated. The cancer is gone, but the net result is that he lives, unable to speak or wait on himself; he is fed through a Penrose tube because what he would swallow would otherwise go into his lungs. He cannot live long, but while he does, he will be an unreasonable burden to society and a torment to himself. But there is no cancer.

I have had to watch this man every day on my rounds for the last two months. I can only say that in these situations, only your good judgment can decide how you are going to handle your individual cases.

In closing, I can only give you my personal philosophy, which is that we, as physicians, have at times the duty to be present at the end of a life, even though untimely, and that it should be done with grace, without pain and without expensive, frantic attacks against a hopeless disease process.

Finally, I would add to that a pithy, but much used and excellent quotation:

"O God, grant me serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference."

MAKING A GRACEFUL EXIT

Peter Pineo Chase, M.D., *Editor-in-Chief,* Rhode Island Medical Journal; Past President, Rhode Island Medical Society, *and*
Irving A. Beck, M.D., Physician, Department of Medicine, Rhode Island Hospital

As you know, this part of this panel discussion was to have been delivered by Doctor Peter Pineo Chase. Some days after Doctor Chase passed away, Doctor Clark called me and asked whether I would pinch-hit in this part of the program. I really accepted under false pretences. A pinch-hitter is a player who can be expected to do better at bat than the player he has replaced. Those who know of Doctor Chase's abilities, particularly in handling a subject of this type, will recognize that our Society could no more send a pinch-hitter in for him than the Red Sox could for Ted Williams. Rather, to go from the diamond to the gridiron, I find myself in the position of the second stringer who is called upon to carry the ball when the star back has been removed from the game by an accident.

Doctor Chase's last activity was the drafting of the talk he was to deliver here today. I believe that this draft contained a good deal of what he intended to say, and as his style was inimitable, I shall proceed to quote directly.

"When I (Doctor Chase) was in medical school, Doctor Minot was accustomed to deliver a special lecture to each class. One piece of advice he reiterated was:

" 'Never tell an old woman she is about to die, for she may live to dance upon your grave.' "

"This was good advice for the medical profession just as Doctor Minot put it. Never underestimate the power of a woman, nor of nature. Good nursing may pull a hopeless patient through just as it did in the days before miracle drugs when it was said that the best thing you could do for a man with pneumonia was to put him to bed with a good nurse.

"Of course, the day has long gone when we have considered people hopeless because they were elderly. In the Rhode Island Medical Journal in 1949, Doctor Basilevich contributed a paper on his long-term study of seventy-odd people who had lived to be nonagenarians or centenarians. He had found nearly all of them to be healthy individuals. They had a good many of the changes which we expect to find in very old people, but they were still functioning well. His thesis was that if a person did not inadvertently become attacked by disease or accident, he might be expected to live well over a hundred years. So, we must bear in mind this possibly cheerful prospect and in a great many ways treat our elderly patients as though they were in Doctor Chapman's category—the prime of life. In doing this we must have a high standard of achievement, and it is clearly not to be attained by routine prescriptions, cathartics, diets, sedatives, nor by perfunctory pats on senescent scapulae. It is for science not only to add years to life, but more important, to add life to the years.

"This brings up one important point in helping the aged to make a graceful exit. Be very slow to change their lifelong habits. An eighty-year oldster had a lower lip cancer removed. The head of the clinic told him to give up smoking, as that was a factor in lip cancer. The patient sorrowfully told me that we were removing almost his only remaining comfort. I told him to keep on smoking. The clinic head put on the record that I had countermanded the instructions. At the old gentleman's next birthday, Doctor Herman Pitts and I gave him a box of cigars. Sir Walter Scott showed good medical judgment when he wrote: 'Even an admitted nuisance, of ancient standing, should not be abated without some caution. . . . We are not made of wood or stone, and the things which connect

continued on next page

themselves with our hearts and habits cannot, like bark or lichen, be rent away without our missing them.'

"A reading of modern medical literature, some of it in medical magazines, more in the public press, would suggest that there is little necessity for exits at all any longer. But of course there are going to be plenty. You physicians know that the final passing away of a human being is usually not at all hard on the principal actor. Bryant in his THANATOPSIS describes how he 'wraps the drapery of his couch about him and lies down to pleasant dreams.' There is the pleasant picture of Doctor Oliver Wendell Holmes in one of his last moments, looking up at his son and saying: 'Well, son, what will it be, King's Chapel?' and going quietly to sleep when he had received the nod of acquiescence. Unfortunately the events leading up to these quiet scenes are often pretty tough and tax the ingenuity of the physician as well as the stoicism of the patient. Once again our optimistic medical writings, and even more cheerful medical advertisements, lull us into a hopeful state. There is no doubt that we can generally do better than we did in the old days. Our barbiturates, snakeroot, chlorpromazine, meprobamate, and, when worse comes to worst, the old reliable morphia, or whatever the up-to-date fellows put in its place, must undoubtedly be used for the real sufferers. The neurological surgeons are learning better and better how to interrupt the pain pathways.

"I have just been looking over the tremendously heavy tome that Doctors James White and William Sweet and associates have brought out. One who has seen much cancer, realizes the importance of such a work. Cancer, unfortunately, often moves too slowly towards the inevitable. In the old days, when rodent ulcers of the face were more common than they are now, I saw a pitiable housewife so afflicted, and she said to me, 'If it was Rover there, you would put him away, wouldn't you?' Religion and law prohibit that, and morphia fails us in such cases. When the surgeon cannot get ahead of the pain, we must rely more on the method of Doctors White and Sweet.

"We all realize now that a lot of these 'hopeless' cases are going to stick around for a long time. One of our local physicians made a diagnosis of leukemia on a woman, and there was plenty of time to confirm it, for she lived a quarter of a century more. Years ago I learned that a brilliant lawyer had leukemia. He has gone steadily up the judicial ladder, and I would not be surprised if he reached the U. S. Supreme Court. His chances seem better now than when I first knew him, for he is a Republican.

"These people who are on their way out, will not do it gracefully unless we help to put them at their ease, for the ill-at-ease are awkward. We have many excellent new developments for this, a few of which I have just mentioned. In addition is the increased appreciation by the medical profession of the psychosomatic approach to most of our problems. In fact, this approach goes far beyond the awareness of most doctors.

"It is my belief that the most valuable medicine we have ever had has been the placebo. It helps out the physician and the patient alike, and whatever helps number one, of course reacts to the benefit of number two. There was a striking example of this in my medical school days. Few if any of you will deny the value of digitalis for many elderly flagging hearts. An able young Boston physician had his suspicions aroused so that he collected samples of digitalis from drug stores throughout the city. He found most of them to be old and inert, but administered by believing physicians to believing patients, they slowed and strengthened ailing hearts as efficiently as did the mixtures of herbs from the Shropshire gardens where Withering found digitalis. Fresh, it was a powerful drug. When old and weak it still continued to work its wonders as a placebo. Certainly the hopeless ought to feel that you have not given up their case as hopeless but are always working for them hopefully.

"Several times in the good old days, I covered for some of my internist chums while they took a breather. As I claimed to be only a surgeon, I knew nothing about hearts, kidneys, and livers, which in those days were the domain of the medical men, but I did recognize that the patients had estomacs delicats, which I learned from old Cointreau bottles, meant delicate stomachs. So I usually cut out the digitalis, colchicum, and nauseous cathartic mixtures they had been taking. Presumably, it would have been bad for the patients to be left long in my care, but they certainly enjoyed a short respite from more intense therapeutics. The moral of all this is: —Be especially careful not to overtreat the hopeless case.

"This problem of a graceful exit is put up, I presume most often, to the general practitioner, as most of medicine's problems are put up to him sooner or later. I wonder if the rule still holds good, as it did in my youth, that a few chronics would support a doctor. Grandmother was chronically ill for years before she died. Mother had Doctor Doane come in at intervals, not for his pharmacopoeial help but because his cheerful presence was good medicine. I trust that you are not, most of you, too proud now to render that kind of service. Even in this era of wonders, the great majority of ills of the flesh are either self-limited or are going to progress despite all our scientific acumen.

"Humbly bearing this in mind, let us help nature when we can, to expedite cures; with discretion let us keep our hands off unless we see a reasonable chance of helping, and with fervor and kindliness

help our hopeless friends to progress smoothly and gracefully through their last exit."

Thus spoke Peter Pineo Chase.

It is one thing to give good advice, and quite another to live it. Those of us who had the privilege of being with Doctor Chase during his last illness, observed how well he lived out the philosophy he summarized in the phrases I have quoted. Certainly no man ever made a more graceful exit from life, and I am certain that he was thinking of his own reactions as he was composing this talk.

In the time that remains, I would like to discuss more specifically the practical implications of some of the points Doctor Chase emphasized. What can we do as physicians directly to assist our aged patients in their graceful exits? I think that the most important advice in this connection is the old aphorism of Hippocrates—*Primum non nocere*—the first rule is to do no harm.

Doctor Chase mentioned the distress and difficulty of applying certain restrictions. To be specific, one might consider the unnecessary dietary restrictions that are often imposed upon the aged. The elderly man, with a moderate systolic hypertension, has often had the savor of his diet denied to him because he has been ordered not to add salt to his food. In the absence of congestive failure or edema, there is no scientific basis for such salt restriction, for it has been shown that to get any therapeutic value from sodium restriction, one has to eat a diet containing well under one gram per day. And even if one were to restrict the diet within this effective range, it is unlikely that any beneficial effect as regards the hypertension would occur. Similarly, it is surprising how many oldsters still follow the "red meat" fallacy and avoid the high quality protein which might more nourish their shrinking muscles than the tea and toast they favor. Indeed some of you may remember Doctor Alex Burgess's study indicating that individuals over fifty, with even greater hypertension, attained practically their normal expected longevity.

Along this line, because of recent biochemical studies, largely experimental and based upon experiments with chickens and rabbits, it has become the fashion to deny the patient with arteriosclerosis, particularly if he has coronary artery disease, a normal amount of dietary fat. It is hard to conceive how deprivation of the eggs, butter, and bacon, which so many people find the most appetizing part of their diet, can soften vessels that already are atheromatous or calcified. Perhaps in the younger coronary, with a high blood lipid, there may be some justification for such restriction, although even here the evidence is largely inferential. But many of the elderly, subjected to this fat deprivation, particularly when the crime is compounded by the omission of salt, feel weak, and for all their misery probably accomplish nothing therapeutically.

The same holds in excessive limitations of activity. Many individuals with serious organic heart disease, for example, can still carry on quite actively at their occupation. Even individuals with rather marked angina of effort can be encouraged to be active just below the threshold producing their symptoms of coronary insufficiency. It is certainly not a graceful exit to sit in the rocker deprived of the spice of life.

Along the same line, there should be limitations on the positive side of therapy, mainly medications, as well as on the negative, namely—restrictions, which we have already discussed. Phenobarbital and other barbiturates are often prescribed to older individuals as freely as aspirin. Yet all the barbiturate sedatives are tolerated poorly. They frequently enhance disorientation, forgetfulness, apprehension, and unsteadiness. The senile are so often confused by barbiturates that they become acutely anxious. One of the distinct disadvantages of the modern, highly purified forms of digitoxin is that in the elderly, digitalis intoxication is more likely to occur because the warnings of nausea are reduced. Alcohol, on the other hand, in moderation, is an extremely useful adjunct in the management of the aged. It relaxes tensions, induces a sense of well-being, and may stimulate appetite.

In addition to the not-doing-any-harm principle, what can we do in a positive way to ease the declining years? Illness, of course, has to be treated, for a long life without health is not only a personal tragedy, but in the aggregate a great economic burden for the country. With due regard for avoiding the eager-beaver attitude in pushing restrictions and multi-medications, no person should be denied the advantages of medical treatment simply because he is elderly. This applies particularly to major surgery, which is now being done more successfully than ever in individuals formerly thought to be too old. Here, however, prudence must guide the surgeon's scalpel. Radical mutilating procedures for cancer are certainly not warranted in the individual with a limited life expectancy. Thus a simple mastectomy may offer the old woman just as much as a radical, and without the considerable discomfort and morbidity that follows the latter. Castration and/or estrogen treatment may offer the old man just as much remission of his prostatic cancer as a total prostatectomy, without subjecting him to the risk and urinary incontinence of the latter. No specific rules can be laid down. The wise surgeon will individualize his cases.

The elderly deserve careful investigation of their complaints, and one must learn not to sloppily attribute many symptoms as being purely due to age.

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CYTOLOGY SCREENING PROGRAM FOR CANCER IN WOMEN OF THE STATE OF RHODE ISLAND

HERBERT FANGER, M.D., Y. S. SONG, M.D., AND THOMAS MURPHY, M.D.

The Authors. *Herbert Fanger, M.D., Director, Institute of Pathology, Rhode Island Hospital; Y. S. Song, M.D., Associate Director, State Cytology Program; Thomas Murphy, M.D., Director of Cancer Control, State Health Department.*

THE State of Rhode Island has been given a grant for two years from the United States Public Health Service for a vaginal cytology screening program in order to detect early uterine cancer. Doctor Thomas Murphy, director of Cancer Control, Division of Department of Health is the program director, and Doctor Herbert Fanger, director of the Institute of Pathology, Rhode Island Hospital has been appointed as the laboratory director. Doctor Y. S. Song, formerly of the Institute of Pathology, University of Tennessee Medical School, Memphis, Tennessee, and Miss Evelyn Dakin, former supervisor of the Cytology Laboratory, Roosevelt Hospital, New York, have been appointed as associate director and cytologist, respectively. Other technical and office personnel have been hired for the survey which will begin to function the first of November. The laboratory will be located in the Rhode Island Hospital.

The results of the first screening investigation performed in Memphis, Tennessee,[1] clearly indicated that the vaginal cytology technique can be utilized effectively in the early detection of uterine cancer. 95,000 women were examined during the first screening in Memphis, representing 50 to 55 per cent of the available female population. In 627 women, or 0.78 per cent of all women examined, early uterine carcinoma was detected by the vaginal cytologic examination and subsequently confirmed by a tissue study. In other words, almost 5 out of 1,000 women examined in the first screening had an unsuspected pre-invasive or so-called intraepithelial carcinoma of the cervix. The result of routine vaginal-cervical smear tests examined in Strang Clinic, New York,[2] from 1948 to 1950 is also significant. During the three-year period, 16,246 women had one or more sets of screening smears. The ages in this group ranged from 20 to 80 years, with more than 50 per cent of the group being between 40 to 60 years of age. In this group of 16,246 examined, there were 45 proved uterine cancer cases. Among the 45 proved cases, there were 32 of unsuspected pre-invasive carcinoma or so-called carcinoma in situ, and 4 were early invasive epidermoid carcinoma of the cervix. According to Pund and Nieburgs,[3] 280 cases of uterine cancer were detected by routine vaginal smear methods in 10,000 women examined in Atlanta, Georgia, in 1950. Of the 280 cases of uterine cancer, 112 cases were carcinoma in situ or pre-invasive carcinoma of the cervix. The above data clearly indicates that the value of genital cytology is firmly established for routine screening for early uterine cancer detection.

Incidence of Genital Cancer in Rhode Island and the Goal of the Cancer Cytology Survey

There is a high mortality rate in cancer of the female genital tract in this country. In 1955 the Division of Cancer Control, Rhode Island Health Department, reported 73 deaths from uterine cancer and 41 deaths from cancer of the ovary or fallopian tube. In 1955, there were recorded 218 new cases of uterine cancer and 52 new cases of cancer of the ovary or tube. There were, therefore, 384 cases of cancer of the female genital tract recorded in 1955. This figure leads us to believe that there are a considerable number of asymptomatic women with unsuspected early uterine cancer. The immediate goal of our screening program is to examine a large percentage of the female adult population in Rhode Island by a vaginal cytologic technique in order to detect incipient cancer of the uterus. These smears will be taken only from women who are asymptomatic of genital tract disease. Smears from patients with gynecologic complaints should be handled by the cytology laboratories in the state. The project will ultimately provide valuable information regarding the specific age incidence and prevalence rate of genital cancer in this state. Together with other investigations in various parts of the country, this study will furnish a more complete picture of the occurrence of unsuspected uterine cancer than is at present available.

Procedure and Plan

The routine procedures for the project consist of a smear of vaginal fluid aspirated from the posterior fornix and a smear of material obtained from

the cervix, concentrating on the region of the external os. As a rule, the routine vaginal smear taken from the posterior fornix of the vagina contains representative cells from all portions of the female genital tract and has great applicability to mass screening. It is believed that the percentage of positive findings can be increased by making additional smears from the endocervix and from cervical scrapings. This was demonstrated in a series of cases from the Memphis project. Therefore, it is our purpose to use the vaginal and cervical smears simultaneously for the project. The technique of taking smears is very simple. Any physician can send or mail the slides to the central screening laboratory where they are stained by a routine Papanicolaou method and examined by screeners. Screening technicians shall be responsible for determining whether the slide is negative or shows abnormal or suspicious cells. All suspicious smears shall be checked by an experienced cytologist and by a pathologist who has had special training in cytology. It should be emphasized that cytological techniques do not take the place of biopsy; therefore in all cases reported as positive or suspicious for tumor cells, a cone biopsy shall be recommended. In other words, the vaginal smear shall not be used as a diagnostic test, but as a screening method to select cases for more extensive study by biopsy. The pathologist has the responsibility of the final interpretation of the biopsy, and he shall correlate them with the vaginal and cervical smears.

The initial aim of this project is to reach a significant percentage of the female adult population in order to test the vaginal-cervical smear as a screening test. In order to accomplish this, one of the major tasks will be to educate and stimulate women to go to their doctors for this test. The indigent will be accepted at clinics established by the Rhode Island Women's Cancer Cytology Survey in various hospitals and health centers of this state.

Advisory Committee

An advisory committee has been appointed consisting of representatives of the Rhode Island Medical Society, Rhode Island Pathologists Association, Rhode Island Cancer Society, Rhode Island Hospital Association, Rhode Island Public Health Nurses Association and the United States Public Health Service. It should be emphasized that this survey is a cooperative venture which will be carried out by the joint participation of the practicing physicians, Public Health Nurses, the staff of the Rhode Island Women's Cancer Cytology Survey, and the pathologists. The pathologists shall be given an opportunity to review all suspicious and positive smears.

Technician Training Program

It is essential to have an adequate number of trained technicians for the cytology laboratory. For this reason, a training program is being established for qualified students. Students should have a minimum of two years of college or its equivalent. The course shall be of six months' duration. Candidates with proper qualifications are invited to apply.

Comment

It should be emphasized that this project shall not supplant the several cytology laboratories of this state. Doctors are advised to continue sending smears from gynecology cases to these laboratories. The Rhode Island Women's Cancer Cytology Survey shall study smears from women who are clinically free of genital tract disease since this is a screening program and not a diagnostic service. On the other hand, doctors are encouraged to take smears as part of their physical examination routine on female patients and in this way furnish a more complete cancer detection service.

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SURGICAL TREATMENT OF ULCERATIVE COLITIS

WARREN W. FRANCIS, M.D. AND NORMAND E. GAUVIN, M.D.

The Authors. *Warren W. Francis, M.D., Assistant Surgeon, and Normand E. Gauvin, Pediatric Resident, the Rhode Island Hospital, Providence, Rhode Island.*

THE PURPOSE of this paper is to review the experience at the Rhode Island Hospital with the surgical treatment of ulcerative colitis and to reemphasize the high morbidity and mortality too often associated with it.

Multiple factors are probably involved in the etiology of this disease. Those implicated by various investigators include ones of bacterial, viral, allergic, enzymatic, and psychogenic nature in varying combinations. Surgical therapy has been aimed primarily at the end result of this disease.

Over the years fewer than 10% of ulcerative colitis cases in most clinics were treated by surgical means. With recent improvements in preoperative preparation, surgical technique, anesthesia, postoperative care, and ileostomy appliances, the percentage of cases treated surgically has increased. By no longer reserving surgery as a last desperate measure and by operating before the patient's condition has completely deteriorated, surgical mortality rates have been markedly lessened.

Material

From 1951 through February, 1956, 18 patients with ulcerative colitis were treated at Rhode Island Hospital by surgical means. These were 22% of the total cases treated.

The age incidence and sex distribution are consistent with most other reports. (Table I)

TABLE I

A. Sex Distribution

Female	12 Patients
Male	6 Patients

B. Age Incidence

Range	12-68 Years
Average	42 Years

The average patient had been having symptoms referable to his disease for 4.7 years prior to his surgical therapy. (Table II)

TABLE II

Onset of Symptoms Prior to Surgical Therapy

Range	6 Months to 17 Years
Average	4.7 Years

Medical Therapy Prior to Surgery

All but one patient in this series had received varying amounts of dietary, antibiotic, steroid, antispasmodic, and psychotherapy. That one patient had received no treatment and was diagnosed as having ulcerative colitis while in the hospital following a rectocele repair.

Indications for Surgical Therapy

Sixteen patients were operated upon because their disease had failed to respond to what was felt to be adequate medical therapy. The remaining primary and secondary indications are listed. (Table III)

TABLE III

Indications for Surgery

A. *Primary*	
Intractable disease	16 Patients
Perineal fistulae and abscesses	1 Patient
Perforation, hemorrhage, and obstruction	1 Patient
B. *Secondary*	
Intractable disease	1 Patient
Carcinoma	1 Patient
Pseudopolyposis	3 Patients
Rectal fistula	3 Patients

Type of Therapy

One patient underwent a vagotomy with some temporary symptomatic improvement. All eighteen patients had either an ileostomy alone or an ileostomy combined with some degree of colectomy in one, two, or three stages. (Table IV). (Table V).

TABLE IV

Primary Operation

Ileostomy	7 Patients
Ileostomy plus partial colectomy	6 Patients
Ileostomy plus total colectomy and abdominoperineal proctosigmoidectomy	5 Patients

TABLE V

Ileostomy plus total colectomy plus abdominoperineal proctosigmoidectomy	11 Patients
A. One stage	5 Patients
B. Two stages	4 Patients
C. Three stages	2 Patients

Complications

All but two of these patients had serious postoperative complications. Seven patients required revision of their ileostomies, three having two revisions. The major complications are listed. (Table VI)

TABLE VI

Postoperative Complications – 89%

Peritonitis	5
Severe electrolyte imbalance	7
Severe ileostomy dysfunction	8
Ileostomy prolapse, stricture, erosion	7
Wound infection	4
Thrombophlebitis	4
Perineal abscess	2
Intestinal obstruction	4
Ileal fistulae	2
Rectovaginal fistulae	2
Traumatic perforation of ileum	1
Hepatitis	1
Pulmonary edema	1
Lung abscess	1
Urinary dysfunction	1

Mortality

There were six postoperative deaths for a total mortality rate of 33%. All patients having only ileostomies died, while those well enough to undergo ileostomy plus colectomy plus abdominoperineal proctosigmoidectomy in one, two, or three stages, all survived. (Table VII)

TABLE VII

Mortality

A. Total	6 Deaths	33%
B. Patients having ileostomy plus colectomy plus abdominoperineal proctosigmoidectomy in one, two, or three stages	11 Patients No deaths	0%
C. Patients having ileostomy alone	4 Patients 4 Deaths	100%

Analysis of Deaths

Five of the six fatal results occurred in patients with far advanced disease and poor nutritional status who were operated upon either as an emergency, semi-emergency, or last resort procedure. The other death was attributed to a probable pulmonary embolus in a man with severe disease following an ileostomy, a second stage subtotal colectomy, two ileostomy revisions, ileostomy dysfunction, electrolyte imbalance, and thrombophlebitis.

Comment

The findings in this study are similar to those in the current literature. The realization that when intractability is present, the patient cannot be returned to a state of normal well-being and useful vocation should lead to lowered mortality rates with early surgery. Although perforation, hemorrhage, and obstruction may remain as primary indications for surgery in the acute fulminating stages of ulcerative colitis, intractability should be the primary indication for surgery in the chronic form of the disease. Mere spontaneous remission should not confuse the picture of a chronically invalided patient with an increasingly rigid, fibrous, and almost useless bowel in which carcinoma may arise without the usual warning signs.

The finding that those patients who underwent ileostomy, colectomy, and abdominoperineal proctosigmoidectomy in one, two, or three stages all survived is of importance and illustrates the fact that patients in adequate nutritional status can survive the surgical procedures. It is ulcerative colitis itself that usually kills the patient.

In view of the recent enthusiasm for the one stage ileostomy and total resection of the colon and rectum, the good results in the four cases treated in that fashion in this series are noted.

Maturation of the ileostomy at operation by everting the mucosa down to the skin has produced a marked decrease in ileostomy dysfunction and is strongly recommended.

SUMMARY

Review of the surgical treatment of ulcerative colitis at Rhode Island Hospital reveals that the high total mortality rate of 33% is closely related to the far advanced stage of the disease and the poor nutritional status of too many of the patients at the time they are initially referred for surgical therapy.

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THE 84th CONGRESS — SUMMARY OF HEALTH BILLS ENACTED IN THE RECENT SESSION AS REPORTED by the Washington Office of the American Medical Association

IN TERMS OF actual health bills passed and sums of money appropriated, the 84th Congress which ended just a few weeks in advance of party presidential conventions undoubtedly set some records. Measures ranged from the far-reaching program of disability cash payments to a bill for the commissioning of male nurses in the armed services.

In between are a wide variety of measures which, in the opinion of Secretary Folsom, Secretary of Health, Education, and Welfare, gives "promise of immediate and substantial progress on a wide front in the improvement of the nation's health."

Both Mr. Folsom and the President deplored the fact that Congress had not acted on their plan for federal aid to medical schools, but Congress decided this was one of the subjects that needed more study before taking any further action. In addition Mr. Folsom expressed disappointment that nothing had been done on authority for pooling arrangements among small health insurance companies and the long-dormant plan for a health reinsurance fund.

On medical research funds, the administration this session asked for the largest amount of money ever requested in one year. The appropriation finally voted was even larger, some $170 million. On top of this, Congress in its final hours appropriated nearly $80 million to carry out new legislation just passed.

Here are the highlights of major health bills approved by the 84th Congress:

Social Security Amendments—Changes in the 21-year-old social security law now include (1) Old Age and Survivors Insurance payments to disabled workers at age 50, paid from a "separate" fund, (2) extension of social security to some 250,000 dentists, lawyers, osteopaths and other self-employed persons, (3) lowering of retirement age for social security purposes for women from 65 to 62, (4) earmarked payments for medical care of public assistance recipients, and (5) increase of payroll deductions by one half of 1% and three-eights of 1% for the self-employed.

Laboratory Research Facilities—The Hill-Bridges bill for $90 million in construction grants over three years to public and non-profit institutions to erect research facilities started out in the Senate as a bill to aid research in crippling and killing diseases but wound up for research in all "sciences related to health."

Health Amendments Act—The so-called little omnibus health bill provides for federal grants for training of public health specialists, professional nurses qualified for teaching and administrative jobs and for practical nurses—plus a two-year extension beyond next July 1 of the 10-year-old Hill-Burton hospital program, and special projects grants for mental health studies and demonstrations.

Medical Care for Military Dependents—A long-sought goal of the Defense Department was enactment of a permanent program of medical care for dependents of armed services personnel either in military hospitals and clinics or through private sources. It is scheduled to begin early in December.

National Library of Medicine—Another proposal long in the making was the reestablishment of the Armed Forces Medical Library as the National Library of Medicine. For administrative purposes, Congress put it under the Department of HEW, but left up to the 17-man board of regents the selection of site—in all likelihood in the Washington area.

Sickness Survey—Special and continuing surveys on the extent of illness and disability in the U. S., along with medical care being offered have been authorized—the first detailed study of its kind in over 20 years. The work will be done by the Public Health Service.

Water Pollution Control—The PHS is authorized to make grants to states and communities to help in construction of sewage disposal plants, at the rate of $50 million a year for 10 years.

Some other measures signed into law by the President were: establishment of a mental health program for Alaska, budget increases for additional staff for the Food and Drug Administration along with a new headquarters building for modern laboratories, provision of medical care for employees and dependents of the State Department abroad in U. S. military facilities, a $400,000 fund to finance the holding of the World Health Assembly in this country in 1958 (which is the 10th anniversary of the founding of the World Health Organization) and the commissioning in the armed services of osteopaths.

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THE LIMITATIONS OF DIAGNOSTIC INSTRUMENTS OF PRECISION — THE ELECTROCARDIOGRAPH

RECENTLY one of our physicians was asked to define a cardiologist. His answer is interesting —"a cardiologist," said he, "is a physician who has bought an electrocardiograph." Unfortunately the intended irony of this remark is lost on many of his colleagues whose limited acquaintance with this newly acquired gadget has inspired a confidence by no means shared by those better versed in the uses and abuses of the instrument as a diagnostic tool. It would be as accurate to assume that our all-round capable diagnostician is a man who owns or has access to a fluoroscope, an instrument for estimating the basal metabolic rate, a chemical and bacteriological laboratory and most of the other mechanical aids that are useful to such a clinician.

Rather we should consider a physician to be able in the field of diagnosis when he first considers his patient as a human being and by careful inquiry determines the nature of his problem, which he attempts to solve on the basis of a study of his personality and his person, using those additional laboratory determinations which experience has taught him are applicable to the situation on hand. Disease, he realizes, is not the presence of infection in the body of a person or injury to that body, but the reaction of a whole human being to such noxious factors.

The electrocardiogram, the graphic record of certain electrical changes in the muscular walls of the heart during contraction, can be of great value as an aid in determining the nature of disease of the heart, but it is just one of a number of tests that aid the experienced clinician, and an exaggeration of its importance is a very common mistake. As pointed out in an article by Doctor Charles E. Kossman in the HEART BULLETIN for March-April 1956, the errors that may interfere with the production of good tracings are many and the pitfalls in the interpretation of such tracings are even more numerous and liable to mislead the enthusiastic, but inexperienced electrocardiographer.

How often have patients suffered needless anxiety and restrictions because of fancied deviations from the normal not substantiated by other evidence, and how often, too, have patients been reassured by the presence of a normal electrocardiogram only to die of heart disease that might have been recognized by other means!

No one will dispute the great value of an electrocardiogram, properly interpreted, as a laboratory

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procedure, but withal only a laboratory procedure that must be fitted into the rest of the clinical picture by the astute clinician. But an adequate diagnosis is not to be made by the method of obtaining the results of multiple diagnostic tests and attempting to put these together like a picture puzzle, but rather by a study of the whole patient as a person, his environment, his occupation, his medical history, his habits, his body in detail by a skillful physical examination and also by the use of such laboratory tests as are appropriate as supplementary and occasionally confirmatory evidence.

A REGIONAL MEETING?

Last year when the American Medical Association staged its Clinical Session at Boston, the Massachusetts Medical Society decided to eliminate its New England Postgraduate Assembly. Announcement has recently been made that the Assembly will be held this fall in November.

It is time that the medical societies of this area gave consideration to the question of whether this so-called New England Postgraduate Assembly meets the needs for which it was originally instituted, and whether it might not be eliminated as a regional meeting in the future.

The complaint of many physicians is that too many medical meetings are held. Certainly the Northeastern region has more than its share, with each of the state societies staging annual sessions, with hospitals conducting periodic staff meetings and of late, special reunion or *refresher* conferences on a large scale, with county societies operating their own programs at local levels, and with specialty associations crowding the calendar further with their regional meetings.

Certainly none of us can acquire too much knowledge of this complex art of healing. But the limitation on our time and energies deserves better consideration by the planners of medical education programs. That is why we advance the thought that the annual Assembly in Boston be eliminated, or else retained by the Massachusetts Society for its own members.

Our position is justified, we feel, when we note that over a five-year span, from 1950 through 1954, the physician attendance averaged only 737 for the entire six-state area with its nearly 13,000 doctors. And the lack of regional nature of the meeting is evidenced by the attendance for 1954 which tallied only 17 physicians from Rhode Island, an equal number from Vermont, only 19 from Connecticut's 3,000 physicians, 38 from New Hampshire, 45 from Maine, and the remaining 674 from Massachusetts and beyond New England.

From the exhibitor's point of view the meeting poses another problem. With all the New England state medical societies listed as sponsors of the Assembly, though they do not support it by attendance or financial aid, the pharmaceutical companies feel obliged to display at the meeting because it presumably is a regional affair, and no company desires to offend the physicians of any of the sponsoring states.

The truth of the matter, we suspect, is that most of these exhibitors would be glad to eliminate the Assembly and concentrate their displays on the various annual state society meetings. After paying all expenses for the Assembly the Massachusetts Medical Society has netted close to $2,000 annually for its own use, and it appears to us that this annual outlay of funds by the exhibitors might be put to better use in aiding the other New England states to expand and improve their local meetings.

We are a region of traditions, but even traditions are subject to the changing times. If the Postgraduate Assembly is to continue in the future, let's make it a truly New England meeting. Otherwise, Massachusetts should take the meeting over under its own name, just as Connecticut conducts its Clinical Congress each September.

DR. WILEY AND PURE FOOD

On June 30, 1906, President Theodore Roosevelt signed the first U. S. Food and Drug Act. Recently, the Federal Government issued a postage stamp in commemoration of Doctor Harvey Washington Wiley, who, in 1906, was chief of the Bureau of Chemistry in the Department of Agriculture, to whose energetic advocacy the Act was largely due. It is, perhaps, a little difficult for us to appreciate that when Doctor Wiley began his campaign Americans were innocently eating plenty of spoiled and adulterated food, consuming tons of bad meat and swallowing gallons of cheap whiskey masquerading as medicine. If you thought you needed a tonic, there was Hood's or Ayer's sarsaparilla; if your nerves were jittery and weak, you could restore their vigor with Peruna or Green's Nervura; if you were a woman, you could soothe your discomforts with Lydia Pinkham's famous remedy or with Warner's Safe Cure; and if you chanced to live here, in Providence, you could banish your aches and pains with Perry Davis's Pain-Killer; should a cough afflict you, Ayer's Cherry Pectoral was at your service. Fifty years ago our citizenry dosed themselves with these and a host of other popular remedies, much as they do today with contemporary fashionable panaceas. Incidentally, it is interesting to recall that there were several families who owed their wealth and social position to the fact that there was a clever mixer of sarsaparilla somewhere in the family tree.

Like most reformers, Doctor Wiley and his supporters were bitterly opposed by powerful segments of the food and drug industries, while, many

times, the press was indifferent or hostile. Although the original Act was full of loopholes which made its evasion easy, nevertheless, as time went on public opinion was slowly aroused so that from time to time the law was amended, extended and strengthened. On June 25, 1938, the new and improved Federal Food, Drug and Cosmetic Act came into being and was placed under the control of the Federal Food and Drug Administration.

That today, we can be reasonably sure we are buying clean and wholesome foods, non-poisonous fruits and vegetables and safe and effective drugs and cosmetics; that labels tell truthfully what is in their containers; that we are free from the plague of electric-belts, aphrodisiacs, nose-straighteners, bust-developers, magnetic rings and other such-like fakes and impostures—for all of these blessings, and more, we are indebted to the assiduity of an almost unknown or forgotten benefactor, Harvey Washington Wiley.

JERSEY'S NEW MEDICAL SCHOOL

Jersey's first Medical-Dental School opened in Jersey City on September 12 of this year when the Seton Hall College of Medicine and Dentistry was dedicated at the Jersey City Medical Center.

Almost a thousand applications for admission were received for the first class of eighty-five medical students and forty dental students. In four years the medical school is expected to have an enrollment of five hundred and the dental school two hundred. The sixteen-story clinic building of the Jersey City Medical Center will be used as a College of Medicine and the nine-story former Isolation Hospital as a School of Dentistry.

Thirteen floors of the clinic building, which will be known as the Seton Hall College of Medicine and Dentistry Building, will be used for teaching research and administration, while three floors now in use by the Medical Center for clinic purposes will continue to be maintained by the Center.

Doctor Charles L. Brown and Captain Merritte M. Maxwell have been named deans of the College of Medicine and the College of Dentistry respectively.

Doctor Brown has been dean of the Hahnemann Medical College in Philadelphia. Previously he had served as an instructor in internal medicine at Harvard, as associate professor of medicine at the University of Michigan, and from 1935 to 1946 as head of the Department of Medicine at the Temple University.

Doctor Maxwell has been chief of Dental Service at the Naval Hospital in San Diego. He had two tours of duty on the teaching staff of the National Dental School in Washington, where he was director of the Interns and Residency program.

CANCER CYTOLOGY PROGRAM

In this issue there is an account of the establishment of a Cytology Screening Program in the State of Rhode Island. This is a project which should furnish valuable information about the incidence of early clinically unsuspected cancer of the uterus. Rhode Island has been given a two-year grant by the United States Public Health Service for this program. Similar projects are being established in other parts of the country. These are located in medical school centers.

This is a cooperative program enlisting the services of physicians in practice, pathologists and public health nurses.

There will be a training program for cytology technicians which ultimately will make available more trained personnel in a scarce specialty.

It should be noted that this program is concerned with women who are "symptom free." Smears from gynecologic patients must be sent to already established laboratories as has been the practice in the past.

Detailed instructions and collection kits for specimens will be mailed soon to the physicians of the state.

ACTIVITIES OF THE WOMAN'S AUXILIARY TO THE RHODE ISLAND MEDICAL SOCIETY

Dinner Dance—October 6

THE FOURTH Annual dinner dance of the Auxiliary will be held at the Sheraton-Biltmore hotel on Saturday, October 6, starting at 8:00 P.M. Dress is optional. Tickets are being mailed to all members who are urged to make early reservations. This annual social event benefits the Auxiliary's Community Service Fund which will include assistance to nurses in training, the Benevolence Fund, the Medical Education Fund, and other community service activities. It is hoped to make the dance this year the most successful ever as a feature of the Auxiliary's 10th anniversary. Mrs. Louis E. Hanna, co-chairman in charge of hostesses, announces the following partial list of representatives of the cooperating hospitals: *Kent County:* Mrs. Richard R. Dyer; *Miriam,* Mrs. Nathan Chaset; *Newport,* Mrs. Charles Dotterer; *Pawtucket Memorial,* Mrs. Rudolf Jaworski; *Rhode Island,* Mrs. William Leet and Mrs. Henry Fletcher; *St. Joseph's* and *Our Lady of Fatima:* Mrs. Frank Jadosz; *Roger Williams,* Mrs. Edmund Billings; *South County,* Mrs. Attilio Manganaro; and *C. V. Chapin,* Mrs. Thomas L. Greason; *Woonsocket,* Mrs. Henri E. Gauthier; *Westerly,* Mrs. F. B. Agnelli.

New Members Welcome

The Auxiliary exists primarily for public service, to promote health education and good-will, and for fellowship. The only requirement for membership is to be the wife, or widow, of a physician who is or was a member of the Rhode Island Medical Society. Anyone wishing to join the State Auxiliary should apply to the chairman of the Membership Committee at the time of the fall meeting (October 24), or telephone Mrs. Donald Larkin at REgent 7-4949.

Fall Meeting—October 24

The fall meeting of the Auxiliary will be held in the Garden Room at the Sheraton-Biltmore hotel on Wednesday, October 24, from 3:30 to 5:30 P.M. The program for the meeting will be announced later. This meeting will be followed the same evening by the dinner-meeting of the Interim Session of the Rhode Island Medical Society which will be held in the ballroom of the hotel at 7:00 P.M., preceded by a social hour in the foyer of the ballroom.

Parcel Post Packages

Early in July, mailing stickers for parcel post packages were sent to all Auxiliary members by the Ways and Means Committee. The plan calls for the use of the stickers by members in mailing $1 gifts from "anywhere," preferably in the wrappings of the shop where the gift is purchased. These package gifts will be sold *unopened* at the Parcel Post booth at the annual bridge in April which will replace the rummage sale conducted in former years by the Auxiliary. Members are urged to be on the lookout for unusual and novel gifts in the coming months and to use the special sticker to see that the package reaches the committee.

New TV Series Starts October 10

On October 10, over Station WJAR-TV, a series of weekly television programs on various aspects of medicine and public health will be presented under the supervision of the Public Relations Committee of the Auxiliary with the cooperation of the State Medical Society's public information committee. These fifteen-minute programs will appear each Wednesday morning at 10:00 A.M. on Betty Adam's *Operation Schoolhouse,* an educational television program. Rhode Island doctors will be featured from the different hospitals and localities of the state, as well as other persons working in the various fields related to medicine.

The Committee urgently requests that doctors asked to participate accept the assignment. Any doctor desiring to take part in these programs should communicate with Doctor Arnold Porter, chairman of the state medical society's committee on public relations, or with the executive office of the Society.

Recruitment and Scholarship Programs

The recruitment and scholarship committee plans to enlarge upon its activities during the coming months. Its program will be twofold: 1) to establish student nurse loan funds in the various hospitals throughout the state, as a means of aiding needy students in training, with the loan to be paid back at a low interest rate after the student has been a graduate for two years, and 2), to assist in recruiting applicants for *all* professional hospital positions, such as occupational therapist, social worker, medical technologist, as well as practical and pro-

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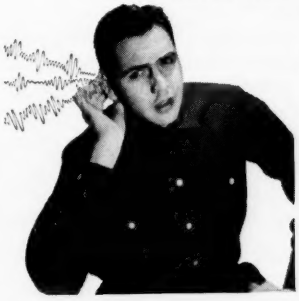
Notes on the Diagnosis and Management of "Dizziness"

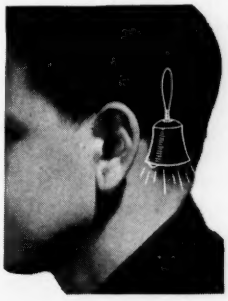
III. Ménière's Syndrome

1. Paroxysmal Whirling Vertigo. *This consists of sudden attacks of dizziness, often when the patient is at rest or asleep. The patient may feel that he himself is whirling or that fixed objects about him are whirling. The attack usually lasts for a few minutes; occasionally it is severe for weeks or subacute for months.*



2. Subtotal Hearing Loss. *Deafness will usually affect the high tones and it may be unilateral or bilateral. Sometimes the hearing loss is severe and also progressive.*

3. Tinnitus. *This is usually unilateral and present in the ear with greater hearing loss and is without a definite pattern.*



Fewer diagnostic errors[1] will result if a "triad of symptoms" is required of patients with suspected Ménière's syndrome. These are the symptoms of typical Ménière's syndrome:

1. Severe paroxysmal vertigo which may be of two types; either the patient feels that he is whirling or that objects about him are whirling.
2. Fluctuating subtotal hearing loss, usually affecting the higher tones, is noted at the same time as vertigo.
3. Tinnitus, usually unilateral, is associated with the deafness and dizziness.

With Ménière's syndrome there is no definite localization[2] by the Bárány (vestibular reaction) test and results of the caloric test are not diagnostic. Physical examination should rule out disease of the central nervous or cardiovascular systems before a diagnosis is made.

"Treatment with Dramamine®. . . is effective[3] in aborting and preventing attacks of Ménière's syndrome . . . will prevent or arrest attacks of vertigo. It will also reduce the intensity of the tinnitus and so may save some of the hearing in the affected ear."

Dramamine is recommended for Ménière's syndrome as the sole therapy or in combination with other treatment programs.

It is a therapeutic standard also for motion sickness and is useful for relief of nausea and vomiting of radiation sickness and fenestration procedures.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.); Supposicones® (100 mg.); ampuls (250 mg.); liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

1. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.

2. Jackson, C., and Jackson, C. L. (editors): Diseases of the Nose, Throat, and Ear, Philadelphia, W. B. Saunders Company, 1945, pp. 368; 414.

3. Queries and Minor Notes: Ménière's Syndrome, J.A.M.A., *141*:500 (Oct. 15) 1949.

DISTRICT MEDICAL SOCIETY MEETING

WASHINGTON COUNTY MEDICAL SOCIETY

A quarterly meeting of the Washington County Medical Society was held at the Dunes Club, Narragansett, Rhode Island, on July 11, 1956. The meeting was called to order by the first vice president, Doctor Frederick C. Eckel at 11:30 A.M. Twenty-four members and three guests were present.

The minutes of the previous meeting were read and approved.

A communication from Doctor F. B. Agnelli in the form of a resolution concerning attendance of members of the Society at legislative hearings at the State House was read. After discussion the following resolution was adopted:

"That the Society be apprised by the executive secretary of the Rhode Island Medical Society when he thinks physicians should be present at legislative hearings. At this time the president of the Washington County Medical Society must delegate at least six members of the Society to attend such hearings, and should urge all members, by mail, to attend the hearing and lend their efforts in matters that are discussed. A detailed report of the activities must be presented to the Society. If the matter warrants a special meeting of the Society, this meeting should be called by the president. The officers of the Society must also attend these hearings."

A communication from the Secretary of the Pawtucket Medical Association concerning professional fees was read. It was moved that the Secretary notify the Pawtucket Medical Association that the Washington County Medical Society has no authorized schedule of fees.

Other communications presented included one from Senator Raymond A. McCabe relative to chiropractic legislation before the General Assembly, two from the secretary of the American Medical Association, and one from the medical co-ordinator of the Rhode Island Council of Defense.

Doctor Samuel Nathans reported on actions taken at the most recent meeting of the Council of the Rhode Island Medical Society.

A motion was adopted instructing the secretary to communicate with the polio committee of the Rhode Island Medical Society regarding the availability of polio vaccine.

Doctor William B. O'Brien, of the State Sanatorium at Wallum Lake, as guest speaker at the meeting, gave an informative talk on tuberculosis. He stated that one major reason why tuberculosis has not been eradicated is due to the fact that treatment is not begun early enough. It is more difficult to keep patients under control because the use of drugs has led to over simplification in the treatment, and to a false sense of security. Surgical procedures are still useful and often necessary for best results. Home treatment should be discouraged. Chemotherapy must be continued over a long enough time and usually varies from one to two years depending on the conditions.

E. T. GALE, M.D., *Secretary-Treasurer*

WOMAN'S AUXILIARY

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fessional nursing.

A study is now under way on the progress made by the students who received scholarships in previous years in order to evaluate the usefulness of this fund program as a basis for future planning.

During the coming months it is hoped that panel discussions may be held in the various high schools relative to the professional positions noted above, with Auxiliary members participating as speakers.

First Aid and Home Nursing Courses

The committee on civil defense, safety, and community health is planning first aid and home nursing courses to help members become better acquainted by participation in tasks in which members have a mutual interest. In addition, the committee believes that every doctor's wife should take advantage of this type of "postgraduate" education or indoctrination, as the case may be.

The First Aid Course will be held weekly from Monday, October 15, for a period of nine weeks, from 1:00 to 3:00 P.M. at the Rhode Island Medical Society Library auditorium, under the instructorship of Mr. Henry Nowell.

The Home Nursing Class will meet weekly at the Red Cross Headquarters on Waterman Street, Providence, from 1:00 to 3:00 P.M., starting October 16, for a period of six weeks. Mrs. Helen Dahl will be the instructor. Auxiliary members are urged to bring friends to these classes. Mrs. Louis A. Sage, of North Scituate, Rhode Island, should be notified by members who plan to attend the courses. Her telephone number is SCituate 1-2213.

FEDERAL RULING ON PRODUCTS CONTAINING RESERPINE AND RAUWOLFIA PRODUCTS

Issued by the Food and Drug Administration of the U. S. Department of Health, Education, and Welfare

The letter below has been sent by the Food and Drug Administration of the United States Department of Health, Education and Welfare to pharmaceutical manufacturers holding effective new drug applications for products containing reserpine and Rauwolfia serpentina. In general it urges reduction of the dosages recommended to physicians in the labeling of these drugs, based upon most recent medical knowledge of their effects. To insure that all members of the Society secure this information the letter is reprinted below.

. . . THE EDITORS

Gentlemen:

This letter is being sent to all pharmaceutical firms holding effective new-drug applications for any product containing reserpine. Its purpose is to make certain recommendations with respect to the labeling of this drug. Although your current labeling may already incorporate many of the following points, it is requested that you give them serious consideration.

When reserpine was first introduced the available evidence suggested that it was a drug of very low toxicity, with no contraindications, and with a wide range of safe dosage. As the drug has been used more extensively it has become increasingly apparent that reserpine is not the innocuous substance it was first thought to be, that there are contraindications, and that the safe level for long term outpatient maintenance is lower than the originally recommended dosage schedule.

A number of firms marketing this drug have voluntarily reduced the dosage they are recommending and have added additional warning statements in their literature to physicians. Firms whose new-drug applications have recently become effective have incorporated many of these changed concepts into their labeling. However, the labeling of many preparations that have been marketed for a longer time fails to reflect these new data.

Papers and exhibits presented at the meeting of the American Medical Association held in Chicago June 11-15, 1956, emphasized the importance of apprising physicians of the latest information on the potential hazards of reserpine. There is an urgent need to bring all reserpine labeling into conformance with the best current available knowledge and to insure that this information reaches the practicing physicians.

In the treatment of hypertension, or of anxiety states on an outpatient basis, it is the present consensus that the usual recommended maintenance dose should be 0.25 mg. daily. While doses up to 1.0 mg. daily may safely be recommended for the initiation of therapy, they usually should not be continued for longer than a week. No substantial benefit is obtained by larger doses sufficient to compensate for the added hazard. An occasional patient may require up to 0.5 mg. daily as a maintenance dose, but if adequate response is not obtained from this dosage, it is well to consider adding another hypotensive agent to the regime rather than increasing the dose of reserpine.

Continued use of reserpine in doses of 0.32 mg. daily has been shown to increase gastric secretion and gastric acidity in a significant number of cases whereas daily doses of 0.25 mg. have not been shown to do so. Doses of 0.5 mg. daily for as short a time as two weeks produced this effect in most of the individuals tested and have resulted in massive gastro-intestinal hemorrhage or perforation of an ulcer. More important, reserpine in daily doses of 0.5 or 1.0 mg. produces severe depression in a significant number of individuals, and has precipitated a very considerable number of suicidal attempts, some of them successful. Many of these depressions have been severe enough to necessitate long-term hospitalization in psychiatric institutions. For these reasons it is believed that reserpine in daily doses above 0.25 mg. is contraindicated and in lower doses should be used with caution in patients

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FEDERAL RULING ON DRUGS

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with a history of mental depression, peptic ulcer or ulcerative colitis. Furthermore, physicians should be specifically cautioned with respect to the danger of depression, and should be urged to follow their patients carefully with this in mind, and to alert responsible members of the family to the hazards. The same general principles should apply to the labeling of Rauwolfia serpentina.

The optimal dose of reserpine in the treatment of institutionalized psychotic patients is not equally well established. There is no general agreement as to the safety of dosages higher than 5 mg. daily, and it is believed that the usual maintenance dose should be stated as 2.0 mg. daily. Labeling of the higher strength tablets of reserpine intended for neuropsychiatric use should contain prominent warnings that reserpine should be discontinued for approximately one week before instituting shock therapy, since it may result in increased severity of convulsions, respiratory difficulty, and other complications; that a syndrome suggestive of Parkinsonism develops frequently in patients on large doses of reserpine but is usually reversible upon lowering the dosage or discontinuing the drug; and that the possible dangers of hypotension and fluid retention should be borne in mind when large doses are used in debilitated patients or those with cardiac disease.

Reserpine tablets of 0.1, 0.25 or 0.5 mg. are suitable for the treatment of hypertension and mild anxiety states. Reserpine tablets of 0.75 mg. potency or higher are suitable only for use in the neuropsychiatric treatment of hospitalized patients under carefully controlled conditions, and the labels should state "For neuropsychiatric use only." In view of the wide variety of dosage forms available it is important that the label declaration of the strength of the tablet should be very prominent, and preferably should be of a different color from the rest of the label in order to obviate any chance of 1.0 mg. tablets, for instance, being dispensed in error as 0.1 mg. tablets.

In our opinion it is important, in the interests of safety, to incorporate the above concepts in your labeling for reserpine. Accordingly, it is requested that your labels and labeling be revised, if indicated, to reflect the changes suggested above and submitted as a supplement to your new-drug application at your earliest convenience. Your cooperation will be appreciated.

Sincerely yours,

RALPH G. SMITH, M.D.
Chief, New Drug Branch
Bureau of Medicine

EXCERPTA MEDICA

(The manuscript of this poem, which appeared during the first quarter of the nineteenth century, was said to have been found in the Museum of the Royal College of Surgeons, London, near a perfect human skeleton, and to have been sent by the curator to the MORNING CHRONICLE for publication. It excited so much attention that every effort was made to discover the author, and a reward of fifty guineas was offered for information that would reveal its origin. The author preserved his incognito, and, we believe, has never been discovered.)

To a Skeleton

'Behold this ruin! 'Twas a skull
Once of etherial spirit full.
This narrow cell was Life's retreat;
This space was Thought's mysterious seat.
What beauteous visions filled this spot!
What dreams of pleasure long forgot!
Nor hope, nor joy, nor love, nor fear.
Has left one trace of record here.

'Beneath this mouldering canopy
Once shone the bright and busy eye:
But start not at the dismal void—
If social love that eye employed,
If with no flawless fire it gleamed,
But through the dews of kindness beamed,
That eye shall be forever bright
When stars and sun are sunk in night.

'Within this hollow cavern hung
The ready, swift, and tuneful tongue:
If Falsehood's honey it disdained,
And when it could not praise was chained;
If bold in Virtue's cause it spoke,
Yet gentle concord never broke—
This silent tongue shall plead for thee
When time unveils Eternity!

'Say, did these fingers delve the mine,
Or with the envied rubies shine?
To hew the rock, or wear a gem
Can little now avail to them;
But if the page of Truth they sought,
Or comfort to the mourner brought,
These hands a richer meed shall claim
Than all that wait on Wealth and Fame.

'Avails it whether bare or shod
These feet the paths of duty trod?
If from the bowers of Ease they fled,
To seek Affliction's humble shed;
If grandeur's guilty bribe they spurned,
And home to Virtue's cot returned—
These feet with angel wings shall vie,
And tread the palace of the sky!'

The Study of Anatomy
by
S. E. WHITNALL, M.A., M.D.

MONDAY, OCTOBER 8 8:30 P.M.

Meeting of the

Providence Medical Association

Note Change in Date!

HELP FOR THE HOPELESS

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The frequent occurrence of unrecognized myxedema in the elderly is a prime example of this, a condition where the patient may be often completely rehabilitated by a little thyroid.

And along the psychological side, every physician treating the aged is, more than with any other group, by virtue of necessity, a psychiatrist. The truly aged frequently feel extremely insecure. Illness frightens them. Because of their physical dependency, the elderly become emotionally dependent upon their physicians, and they are more deeply and warmly grateful for assistance, kindness, and patience than any other group.

In this talk, based upon Doctor Chase's notes and the observations and conclusions that I have added, I have tried to point out in a very general fashion, some of the ways in which we as physicians may assist, or at least not detract from, our older patients making a graceful exit.

DISCUSSION

Presiding: **SAMUEL D. CLARK, M.D., President, Rhode Island Chapter, American Academy of General Practice**

CHAIRMAN CLARK: Ladies and gentlemen, for our discussion period, I am going to ask our speakers some questions and I hope that you, too, will have some questions.

My first question concerns a thirty-five-year-old insurance man, who looks the picture of health; he has a little weakness in one hand, and as far as I know at the present time, his situation is hopeless. He has amyotrophic lateral sclerosis.

First are you going to tell this man what he has, and secondly, how are you going to tell him?

I, for one, would like to know the method you would use in telling this man what his situation is, and first, I am going to ask Doctor Chapman.

DR. CHAPMAN: If you will change that word to multiple sclerosis—

CHAIRMAN CLARK: I think of the situation, purposely, as being more acute, and the prognosis one of a more rapid disease, as opposed to multiple sclerosis, which can continue over a long period.

DR. CHAPMAN: I have been through this with a thirty-five-year-old man who is an executive with one of Boston's leading stores, who insisted on knowing the truth. I can tell you how we worked it out, for the principles are the same.

It was interesting that this man had come to me for an opinion, because his mother had been to me with a toxic goiter, some years before. She knew, also, that I was a sort of diagnostician, and respected me, so she wanted her son to come to me.

When he came to me, he had already seen an eye doctor and he had been to a medical man on Marlborough Street, an able man, who had been evasive and had said:

"Well, don't worry; it's a little neuritis, and it will pass off."

When he came to me I didn't say much the first time. However I did say to him,

"I will give you the answer to this at a later date. I want to talk to your mother and to your wife. It will all work out. Give us a little time."

After my discussion with his family, it was agreed that the diagnosis was multiple sclerosis. The mother feared the diagnosis, and asked me not to tell him. His wife was in tears. But, this patient had been to an eye man, and knew that the disease was progressive. I suggested putting him in the hospital for a few days, and there getting the evidence to clinch the diagnosis. Then, we would have another consultant see the man, and after that, I would have him come into my office and I would talk to him. I would lay the cards on the table. I would not do this while he was in the hospital.

I finally devoted an hour of my time at the office going over the situation with him, and he took it very well. He kept right on with his work; in fact, he is still at work. I have done only one further thing. Now, of course, everybody has read the literature on multiple sclerosis. He has made a trip to New York and consulted with the head of the Multiple Sclerosis Foundation; he has seen him once, and he is perfectly satisfied. Now he sees me only occasionally.

I don't see any reason for not facing the situation. You have to tell him that according to all medical knowledge, his life expectancy is limited, and yet he can live effectively.

CHAIRMAN CLARK: How limited is it?

DR. CHAPMAN: He should have time to put his business affairs in order, as well as his life insurance papers.

DR. SMITH: I don't know about the prognosis, because it is a long time since I have had to think about such matters.

CHAIRMAN CLARK: I'd say this is one to three years.

DR. SMITH: If all this man knows is that he has a little trouble with one hand, I think that he ought to be told about this; and he should not be left to coast along. It seems to me that an intelligent man who is thirty-five years old and expecting to live until sixty or so, would want to know that he had about three years instead of twenty-five. But let us see what others think.

DR. BECK: At first, I thought you were going to refer to Lou Gehrig. They showed the story of his life on television last week, and when they broke the story to him, he was just about the same age. I thought it was very well done. It was a dramatization of the Lou Gehrig Story.

I pretty much agree with what has been said here, assuming the diagnosis is correct, that one has to tell the individual that there is no cure for the disease.

However, I don't feel that we should set a time limit. I think it is true that we have seen diagnoses made erroneously, and perhaps in the case you have mentioned, the diagnosis might be confused with other forms of muscular dystrophy.

CHAIRMAN CLARK: Then, you would say what?

DR. BECK: I would advise him to make his plans.

CHAIRMAN CLARK: He will ask you how long is he going to live, and what would your answer be?

DR. BECK: I don't believe you can say.

DR. CHAPMAN: I was faced with this five years ago, when a vice-president of a large insurance company came to me with an acute attack of gout. I missed the diagnosis on the first two trips; then I got a white count and found it to be 17,000, and the second time he came back it was 48,000. He was a little older than your man; he was about forty-nine years old. He died at fifty-four.

Finally, in the course of the discussion, I told him that the average duration of myeloid leukemia was pretty close to three years, and that despite all the newer drugs, it had not changed a great deal. With careful management and the newer drugs, we would see what would happen, and perhaps if the claims for the newer drugs were true, he would have a longer life.

He took it very well. He organized himself, and worked until within two weeks of his death, which was caused by a cerebral accident. He lived for four years and two months. During the last year, he faced his affliction wonderfully well. He knew it all the way and followed his program carefully.

CHAIRMAN CLARK: Doctor Smith, in the case of the child with leukemia, let us say acute leukemia, the parents have heard about some Doctor *X*. out in Watertown, New York, who has a

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miraculous cure, and you are sure that it is out-and-out quackery, and yet they have heard glowing reports of this treatment for leukemia. What is your attitude in such a situation? Would you say:

"That guy is a quack; he's stealing your money."

Or, are you going to say:

"You might try it."

Thus, giving them some hope.

DR. SMITH: I always tell them, and you probably do the same thing, that nothing in medicine travels so fast as news of really proven advances in therapy, and I say that if that man were curing anybody, it would get into the medical literature. I would point to the medical journals in the office, and assure them that if at any time I had any word that something had been found that was really curing such children I would certainly let them know about it.

I don't think that I have ever told anybody that a person they wanted to consult was a quack or a crook. But, if you can't make people believe that news of real medical advances travels fast, and that they need not spend money investigating unproved cures, there comes a point when it is up to them to do what they wish. You have given the best advice you can, and if they still want to go to such people, let them go; you can't stop them.

CHAIRMAN CLARK: Are there any questions from the audience?

QUESTION: I have drawn the conclusion from what has been said so far that the speakers are of the opinion that everyone should be told.

In my limited experience, there are very few people who can face the facts, and if you take a hundred men with nephritis, cancer, or leukemia, only 10 per cent of them would stand up under the fact of knowing it. You take away their entire hope, and you give them no hope, when you give them a definite time limit.

My question is this. What is your opinion about the percentage of men who can stand up and face a reality such as this?

DR. BECK: Well, I think there is something to what the doctor has said. You have to know your patient. Some people have such a horror of anything with the word "cancer" in it that they simply cannot take the shock of having a cancer, particularly in those cases where we are dealing with the late manifestations, I think it does add a bad blow to their disease.

EXCERPTA MEDICA

The knowledge which a man can use is the only real knowledge, the only knowledge which has life and growth in it and converts itself into practical power. The rest hangs like dust about the brain and dries like rain drops off the stones.

. . . WILLIAM OSLER

However, there are some people to whom you can talk, who are relatively intelligent and adjusted and they should be told.

One cannot lay down a general rule.

DR. CHAPMAN: I think that what you said, Doctor, was that in your opinion they couldn't stand it. I think that too often the medical thinking has been along that same line, because the teaching that we have had in the medical schools is not to tell them because they "can't stand it" and "they will go to pieces."

I have heard this said, and the curious thing is, I think, that "they" fall into two groups. There are those who never ask a question and who evade asking questions, but you have the sense of feeling that they know. They will never ask you and you will probably never tell them, but there is an understanding between you; they know you are doing all that is humanly possible; they know by your frequent visits and the course of the disease that it is not curable. In fact, those people know the truth, but they just do not want it uttered to them.

The other group consists of those who should know and do not. And they constitute the majority. I think that actually, they could stand it.

In other words, how terrible is death? I use this analogy, and I say:

"Well, now, let's look at what this life is. The process of dying starts soon after you are born. It is a gradual process of wearing out of the body. Some have a long span and some have only a short span, but it comes to all of us. You have got to face it."

I find that if you talk about it in that way many of them will take it. It is right there that the conflict is. You are trying to make up your mind whether they can take it or cannot take it. Frankly, I have yet to see a person go to pieces because of this information. I have been told that it happens.

We have a man on our ward who is an alcoholic and a hard-working fellow. He had a cancer of the lung removed, and in a little while another cancer appeared. He was full of metastases. He went back to work. And when he came on the ward three weeks ago, his record showed that he had worked at his machine every day, up to three days before he came in. When he came in the last time, he had a big cancer of the right lower lung. They explored it, and found it inoperable. They have taken him off the alcohol and his reaction is simply astonishing. He has adjusted remarkably well to the total situation.

No; I haven't seen them go to pieces. I have had families threaten me that if the patient were told, what would happen. But somehow or another, human beings do adjust and live with it and they do not really go to pieces.

DR. SMITH: I see something of this astonish-

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HELP FOR THE HOPELESS

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ing adaptability and adjustment in the willingness of many mothers to have babies with little or no analgesia. Many of the doctors are so positive that no mother wants to feel the least pain in childbirth they find these women are just very provoking in asking if they couldn't have less anesthesia. The obstetrician is also somewhat surprised at the fact that now and then a young girl wants to nurse a baby; he wonders why in the world she wants to go to all that trouble.

Perhaps this is the age of "do it yourself" for mothers too. The father doesn't have to make a bookcase; he can buy a bookcase. But, working in an insurance office, as he does, he likes to get a sense of function out of life, and to show the results of his functioning. So he buys a lot of power tools and he builds a bookcase which is not as good as one that he can buy. But he *wants* to go to all that trouble. This is the same urge that his wife has about nursing the baby.

The "do it yourself" principle also holds true in assessing the performance of a backward child. You can tell the parents yourself if you want to, but it is often better to ask:

"Mrs. Jones, you really don't think he is quite as bright as the older child, do you?"

And she will usually say:

"He really isn't."

In that way you can get them to make the diagnosis themselves; and thus to make and accept the plans.

People can take much more of these functioning aspects of life if we give them the opportunity, and feel a sense of function in so doing.

CHAIRMAN CLARK: Are there any other questions from the floor? If not, I have another situation that is a little different and I should like to touch upon it before we finish up. I want to refer to the case of the person who has had a cancer and has been operated upon. Let us say he is a man who has had a lobectomy, and three months after the operation he is not doing too well; he isn't gaining weight and yet you cannot pinpoint a specific pattern. He wants to know how he's doing, and why he isn't getting better?

It has never been made too clear to him that he had a cancer in the first place.

Now, should he have been told at the outset:

"Yes, we have operated upon you and found a cancer (or tumor)" or bandy the word about.

Or, when you get to this stage, can you take the patient into your confidence and say:

"Well, Mr. Jones, I don't know whether we got it all out, and whether your not getting well faster is because it is a return of the cancer or whether you are just slow in convalescing."

Do we take the attitude that we know it all, that the doctor knows best, and how much may we admit as to the possibility of our errors and deficiencies?

DR. BECK: I think you have to be honest and say that the man had a tumor, and presumably it was all removed. If he is not doing well, then I think perhaps it might be wise to tell the man. You might plant further doubts in his mind. I would frankly tell him the situation.

DR. CHAPMAN: I think what Doctor Beck has pointed out is that you must be careful not to foist the diagnosis on the patient when you, yourself, are in doubt. You suspect he has cancer, but you haven't the proof that he has widespread malignancy. He isn't doing well, to be sure, but I think that if you explain to him that primarily it was a cancer, and you hope it hasn't spread, but you have no proof of its spreading, and that he must continue to follow the program and work the thing out with you, then with that patient, in time, one of two things is going to happen; he is gradually going to have his health restored, or else the relentless nature of the disease will be apparent to him.

You have to be careful not to give him the hopeless attitude and presume that the disease will spread, which may be wrong.

CHAIRMAN CLARK: All of you in the audience must have some problems. Here is a chance to get some more information.

DR. BECK: May I raise a question, Doctor Clark? This is a question regarding one of the points that Doctor Chapman spoke about, and that is the ethical situation of a physician withdrawing from a case, or the ability to say "no." He brought up the Chinese analogy, but somehow, in English we don't have the equivalent for saying "mei yo fa-tze," which, in Chinese, would be the answer.

Very frequently, we find ourselves in a situation where we feel, and particularly in the so-called "hopeless" cases, that we would rather not be the attending physician. How should we handle a situation like that, Doctor Chapman?

DR. CHAPMAN: I have been through this on a few occasions, but I can think of three personal experiences where I simply said there was doubt as to my management, and that I didn't believe I had unity within the family. As long as the patient wasn't satisfied, and wanted me to give him unnecessary treatments, then I said that multiple consultations would only lead to the truth, and so he could count me out.

I think that it is an ethical way to practice, and I know it is in our Code, even though we seldom employ it. I think that by doing this, it has given me a sense of stature, and in the long run it forced the family into a final unity in the situation.

Doctors usually feel that they have to hang on

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once they have started, and they somehow feel that the Code says they must stay with the patient. But I say it is specifically stated that we have a free choice of patients just as the patient has a free choice of physicians.

When things are going badly, I don't think we employ often enough this choice of the physician as to whether or not he will continue with his patient. I think that the Chinese have a little edge on us here.

I would like to hear from Doctor Smith on this point.

DR. SMITH: Well, I don't know. It is my observation that often nothing helps a patient who isn't doing very well with a slow chronic complaint as much as a new doctor, just someone else to ask all the questions all over again; to show a new interest in the patient, someone who doesn't say, "This is what you told me when you came in to my office last February."

Therefore, there may be times when I think that you may offer a good deal of help to a family or a patient if you will suggest to him that you are about at the end of what you can do and that you think maybe someone else can find something new to try.

CHAIRMAN CLARK: Have you any questions you would like to ask, Doctor Chapman?

DR. CHAPMAN: I would like to pose a different one about the single or middle-aged girl who was found to have a nodule in the thyroid and submitted to operation, and then it was found to be an adenocarcinoma. As far as we know, it was totally removed. We know the biology of this tumor, it is a slowly growing one, and usually patients live for many years and never show metastases and so they were completely cured by the first complete operation.

Are you going to tell this girl that it is a cancer and that she has to be seen at regular intervals, or are you not going to tell her?

I have reversed my program in that case, because I felt there was no proof that this is biologically a rapid-growing cancer in terms of years, and to have her frightened all this time would not be right, for I was not going to see her more than once in six months or once a year. In such a case I have tended not to tell all to the patient.

Here again, we are acting in terms of what we know about the biology of this type of cancer. It is different, and for that reason I have chosen to reverse my field and not to tell her.

QUESTION: Are you sure she will return when you want her to do so?

DR. CHAPMAN: No; but that is up to the physician. She should go on the automatic ticker in the appointment book. I keep three or four pages in the back of the book for notes of people I want to have return. So I say that that is the physician's responsibility.

QUESTION: Do you think you should send out the notice?

DR. CHAPMAN: Yes. You can say in the office:

"I will see you in six months or a year or so."

But then, you put it in the book, because you want to feel of her neck for metastases and you want to look her over, and you will find she is only too glad to come in, thinking that it is a routine check-up.

DR. SMITH: To tell her anything else would be as though each time you gave a child a vaccination, you said to the parents that vaccination has been known to produce encephalitis. That is your private question; you have settled with yourself that it isn't an important objection to vaccination and certainly not to be mentioned.

QUESTION: I have a problem. I am very much interested in the emotional aspects of disease. I have a patient who had a carcinoma of the breast removed two and a half years ago, and she was told that; she took it well. Then, sometime after that, she lost her husband of whom she was very fond.

Since that time, she has had two attacks of phlebitis which hospitalized her; recently she was put in the hospital and received X-ray treatments for some of these apparent metastases from the breast, and she had been my patient in some of these recent other episodes.

Then, at home she became worse, and again I put her in the hospital. Before entering the hospital, she developed a paralysis of the left arm and leg, and I considered that to be conversion hysteria from the fear that she knows what has been going on in the past. She says she is going to die, and she just lies in bed, limp; she looks well and is well-nourished.

In the hospital we fed her by tube. After finding there was metastases to the ribs and the vertebrae, and the pelvis, and as there was a high sedimentation rate, we gave her cortisone.

Before sending her to the hospital, I tried to talk to her to talk her out of it and to reassure her in every way I know of, but since I feel that this is a conversion hysteria, everything that has been done seems to be of no avail.

This lady is now at home. We are giving her 100 mg. of cortisone daily; she is going along in the same manner; she looks well and doesn't look sick in bed at all.

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To my mind, she has severe conversion hysteria; she has lost all sensation of pain in the left arm and leg. She had Parkinson's disease in the past, and sometimes when I would try to get a little closer to her, telling her that this was due to her emotional condition she would become very much aggravated, and the left arm and leg would twitch violently. On one occasion, I had to give her 9 grains of amytal to quiet her.

This patient is home at the present time; she is well-nourished, looks well, and she still has this conversion hysteria. I sometimes knocked her out completely for ten or fifteen hours, thinking that a good night's sleep might do something. But, she was the same the next day. She always says she knows she is going to die. And, like some other instances that have been cited here, these people know they have a cancer and they don't want you to know they know it. Her left arm and leg will not move; they are rubbery. She is making no attempt to sit up in bed. She looks well.

I wonder if anybody can make any remarks about such a case.

DR. BECK: First, I would make sure that this is not due to cerebral metastases, giving her the usual tests. If she has conversion hysteria, from the psychodynamics of this condition, it may be very risky to remove the conversion. The conversion is a solution for a patient on a low-grade and inadequate level; nevertheless, it is a type of solution; substituting what is apparently an organic difficulty, as a partial solution, for an emotional problem, which may be a fear of cancer or something of that sort.

Perhaps if you remove the conversion, you are left with the basic emotional problem and you may have an individual greatly disturbed emotionally and much more difficult to handle than when she had the conversion.

DR. CHAPMAN: I would say that she fitted in with the group that you spoke about, and she had gone to pieces under the knowledge of having cancer.

Did you say you have seen this two or three times, now, in your practice in psychosomatic medicine? I don't know, but I think that Doctor Beck has a point there. Some of my psychiatrists have told me the same thing; you must be careful about curing or removing some of these conversions, because if you remove the load, you may drive them towards suicidal tendencies, unless they can get something more objective than the unbearable life, and when they can't find that they become suicidal risks.

What you have to do is to contend with two diseases. It is the fear of the unknown. You can't feel it or see it or find it; yet, they know it is within the system. I really cannot answer it.

CHAIRMAN CLARK: Let us take the situation of the man who is, we will say, sixty-odd-years old, who has a large aortic aneurysm. Over the years you have watched it getting bigger and bigger, and you know that some day it is going to burst, as it usually does.

Are you going to tell the man that he has something which is like a bomb inside his chest, or are you going to tell his family, because if you decide it is not going to be operated upon, that is, if you decide it is inoperable, what about that?

DR. CHAPMAN: What did you do?

CHAIRMAN CLARK: In two cases, I did not tell the individual or his family. One patient was a woman, and suddenly four years after the diagnosis was made she died at 83, while coughing blood all over the place.

The other case was that of a man whom I treated for other things, saying nothing about the aneurysm. When he got a little worse, he was sent to the hospital. In the hospital, he suddenly coughed up a lot of blood and died in ten minutes.

DR. CHAPMAN: So many people live beyond any prediction that you may make as to the future of an aneurysm that you are on pretty shaky ground in trying to predict. You don't know yourself. They may live beyond any reasonable time that you can give them. So that I would not think you were justified in that particular disease in giving an expectancy.

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BOOK REVIEWS

WHEN MINDS GO WRONG by John Maurice Grimes, M.D. The Devin-Adair Company, New York 1954, $3.50

This book is written by a man who has an excellent command of the English language, who is able to present his ideas in a style vibrating with emotion and indignation for the mistreatment of the mentally ill.

The writer is extremely critical of present-day care and treatment in mental hospitals. He also presents some solutions of his own for these problems.

It is common knowledge that State Hospitals, in spite of the fact that they are making great efforts in rendering medical care to the hundreds of thousands of unfortunates in their custody, are a long way from being able to satisfy all needs. We also know that some aspects of administering this care is not the best that it could be and we feel that such treatment should and could be improved.

However, when we take Dr. Grimes solutions of these problems one by one, or when we read his ideas about the etiology of mental illnesses, we cannot get away from an impression that his solutions are quite unrealistic and at times have a megalomanic trend.

In spite of all this, the book is interesting and should be worthwhile reading for everyone interested in the life and treatment of the mentally ill in mental hospitals of the United States.

SYDNEY S. GOLDSTEIN, M.D.

PREVENTIVE MEDICINE IN WORLD WAR II. Vol. II—ENVIRONMENTAL HYGIENE. Edited by Colonel John Boyd Coates, Jr., Ebbe Curtis Hoff & others. Medical Department, U. S. Army, Office of the Surgeon General. Wash, D.C., 1955. $3.50

This four hundred and four page book is a condensed history and evaluation of the role which the Medical Department of the United States Army played in the field of environmental hygiene. Major health measures required and undertaken in conjunction with an unprecedented mobilization and global employment of the Army are emphasized, particularly from the sanitary engineering viewpoint.

As environmental hygiene covers such a wide range of problems at home, in transport media and in foreign countries, the authors have done well in reducing the contents to easily readable size. They have necessarily eliminated many minutiae which an engineer might have desired to be included, and which might be debatable.

This appears to be a well-prepared history of the Army's sanitation problems, and an excellent reference book of its type.

EDGAR J. STAFF, DR. P. H.

THE PRACTICE OF DYNAMIC PSYCHIATRY by Jules H. Masserman, M.D. W. B. Saunders Co., Phil., 1955. $12.00

THE PRACTICE OF DYNAMIC PSYCHIATRY by Jules Masserman follows his book, PRINCIPLES OF DYNAMIC PSYCHIATRY, and is an 800-page text, divided into five sections.

The major portion of the work is on therapy; remaining sections include clinical investigation methods, evaluation of various syndromes, means of communicating psychiatric material and theoretical considerations. In the appendices we have an outline for examination, the new standard nomenclature of mental disorders, views on training of the psychiatrist and a chapter on mental hygiene. An extensive bibliography ends this excellent book.

The author's approach is multidimensional and with great clarity he presents the various schools of thought, with their points of difference. His purpose, apparently, is to synthesize these into a comprehensive science of behavior.

The need for closer rapprochement between psychiatry and other specialties is emphasized and Masserman devotes considerable space to the practical application of this point of view. He indicates how the physically ill person may benefit from the psychiatric approach and gives detailed descriptions of how psychiatric material may be communicated to referring physicians, attorneys, insurers and so on.

Masserman's account of his original experimental work on the production of neuroses in animals is extremely interesting, suggesting as it does, the possibilities for future research in psychiatry. So rapidly is the specialty expanding that this book, published just a year ago, does not mention the new tranquilizing drugs, nor the recent work done on experimentally induced schizophrenia.

Nevertheless, it is a book which will be found very useful to those in psychiatry as well as in allied fields.

VERA W. FISH, M.D.

HELP FOR THE HOPELESS

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CHAIRMAN CLARK: Would you tell his family?

DR. CHAPMAN: Doctor Beck, would you?

DR. BECK: I think if the man has a disease of that sort, I would not. Doctor Chapman has brought out that you cannot set a time limit, for you can be surprised at the length of time some people will live.

I have a patient with a large aneurysm, and he knows it; he feels pretty good because he has a friend with a thoracic aneurysm, which pulsates wildly, and he knows that this fellow has had pulsation like that for twenty years, therefore he feels that his abdominal aneurysm is pretty good. I do not believe you can predict the life expectancy in aneurysm.

CHAIRMAN CLARK: But you believe in telling him that he has it?

DR. BECK: This is an abdominal aneurysm, and we had to do something about it, so we operated upon him.

CHAIRMAN CLARK: Ladies and gentlemen, I think that we have had these gentlemen on the panel here long enough so that unless there are further questions from the floor, I wish to take this opportunity to thank our speakers and our panel members.

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Two new titles have been added to the Davenport Collection and are available for circulation:

Otto L. Bettman — A Pictorial History of Medicine. With a foreword by Philip S. Hench. Charles C Thomas, Springfield, Ill., 1956.

Thomas A. Dooley — Deliver Us From Evil. The Story of Viet Nam's Flight to Freedom. Farrar, Straus and Cudahy, N.Y., 1956.

Recent Day Fund purchases were:

American Medical Association — American Medical Directory. 19th ed. Chic., 1956.

Association for the Aid of Crippled Children — Mechanisms of Congenital Malformation. Proceedings of the Second Scientific Conference, June 15 and 16, 1954. N.Y., 1954.

Association for the Aid of Crippled Children — Prematurity, Congenital Malformation and Birth Injury. Proceedings of a Conference at the New York Academy of Medicine, June 5 and 6, 1952. N.Y., 1953.

Sterling Bunnell — Surgery of the Hand. 3rd ed. J. B. Lippincott Company, Phil., 1956.

Viola E. Cardwell — Cerebral Palsy. Advances in Understanding and Care. Association for the Aid of Crippled Children, N.Y., 1956.

Collected Papers of the Mayo Clinic and the Mayo Foundation, Vol. XLVII, 1955. W. B. Saunders Company, Phil., 1956.

Gilbert S. Gordan, editor — Year Book of Endocrinology (1955-1956 Year Book Series). The Year Book Publishers, Chic., 1956.

Paul H. Kirk & Eugene D. Sternberg — Doctors' Offices & Clinics. Medical and Dental. Reinhold Publishing Corp., Progressive Architecture Library, N.Y., 1955.

Richard L. Sutton, Jr. — Diseases of the Skin. 11th ed. C. V. Mosby Co., St. L., 1956.

Paul D. White — Clues in the Diagnosis and Treatment of Heart Disease. Charles C Thomas, Springfield, Ill., 1955.

Leonard Wickenden — Our Daily Poison. The Effects of DDT, Fluorides, Hormones and other Chemicals on Modern Man. The Devin-Adair Company, Inc., N.Y., 1956.

Maxwell M. Wintrobe — Clinical Hematology. 4th ed. Lea & Febiger, Phil., 1956.

Review volumes from the Rhode Island Medical Journal were:

John H. Bland — Clinical Recognition and Management of Disturbances of Body Fluids. 2nd ed. W. B. Saunders Company. Phil., 1956.

Charles S. Cameron — The Truth about Cancer. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1956.

Christopher's Textbook of Surgery. Edited by Loyal Davis. 6th ed. W. B. Saunders Company, Phil., 1956.

Howard F. Conn, editor — 1956 Current Therapy. W. B. Saunders Company, Phil., 1956.

L. W. Diggs, Dorothy Sturm & Ann Bell — The Morphology of Human Blood Cells. W. B. Saunders Company, Phil., 1956.

Garfield G. Duncan — A Modern Pilgrim's Progress for Diabetics. W. B. Saunders Company, Phil., 1956.

Rhoda Ellis — A Dictionary of Dietetics. Philosophical Library, N.Y., 1956.

Henry P. Laughlin — The Neuroses in Clinical Practice. W. B. Saunders Company, Phil., 1956.

Preventive Medicine in World War II. Vol. III. Personal Health Measures and Immunization. Office of the Surgeon General, Department of the Army, Wash., 1955.

Edward Podolsky — Management of Addictions. Philosophical Library, N.Y., 1955.

Fellows of the Society have given the following items:

From *Irving A. Beck, M.D.* — Proceedings of the New England Cardiovascular Society, vols. XI, 1952-53; XII, 1953-54; XIII, 1954-55.

From *Edward S. Cameron, M.D.* — Charles L. Scudder, assisted by Frederic J. Cotton — The Treatment of Fractures. 2nd ed. Phil., 1901.

Zeta — The Diagnosis of the Acute Abdomen in Rhyme. 3rd ed. Lond., 1955.

From *Anthony Corvese, M.D.* — Fifty textbooks.

From *Halsey DeWolf, M.D.* — A small "book" containing the vials which once held the cholera medicines used by James J. DeWolf, M.D., 1830-1895.

From *Herbert F. Hager, M.D.* — Charles F. Millspaugh — Medicinal Plants. An Illustrated and Descriptive Guide to Plants Indigenous to and

Naturalized in the United States which are used in Medicine . . . Phil., 1892. 2 vols.

From *James A. McCann, M.D.* — Two hundred and thirty textbooks.

From *Francesco Ronchese, M.D.* — Atti XI Congresso Internazionale Di Medicina Del Lavoro, Napoli, 13-19 Settembre 1954. Vol. 2. Communicazioni.

Marcial I. Quiroga & Carlos F. Guillot — Dermatologia Geriatrica. Buenos Aires, 1955.

Vlasta Rihova — Vady A Choroby Vlasu (Trichologie). Praha, 1951.

Several volumes of periodicals were received from each of the following Fellows: Doctors J. Merrill Gibson, Arcadie Giura, Seebert J. Goldowsky, Louis I. Kramer, Alfred L. Potter, Bernard Rapoport and Francesco Ronchese.

Other gifts were:

American Cancer Society — Annual Report, 1955. Gift of the Society.

American Cancer Society — Cancer of the Lung. An Evaluation of the Problem. Proceedings of the Scientific Session, Annual Meeting, Nov. 3-4, 1953. N.Y., 1956. Gift of the Society.

American Geriatrics Society — The Senescent in Industry: Medical Evaluation of His Employability and Maintenance. Gift of the Society.

Association of Military Surgeons of the U.S. — Mass Casualties. Principles Involved in Management. Papers Delivered at 62nd Annual Convention, November 7-9, 1955. Wash., 1956. Gift of the Association.

Norman Q. Brill & Gilbert W. Beebe — A Follow-up Study of War Neuroses. VA Medical Monograph. Wash., 1956. Gift of the U.S. Government. Gift of the Charles V. Chapin Hospital — Several volumes of periodicals.

Ciba Clinical Symposia, vol. 7, 1955. Gift of Ciba Pharmaceutical Products, Inc.

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, vol. XVI, 1955, parts 1 & 2. Gift of the Foundation.

Gift of Marion I. Dacey, R.N.—Fourteen volumes of periodicals.

Guide for Planning Physicians' Offices. Prepared under the General Direction of John W. Cronin. Chic. Gift of the American Surgical Trade Association.

Proceedings of the Forty-ninth Annual Meeting of the Life Insurance Association of America, N.Y., December 14 and 15, 1955. Gift of the Association.

Luther Holden — Manual of Dissection of the Human Body. Edited by John Langton. 5th ed. Phil., 1885. From the Estate of H. G. Partridge., M.D.

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WEDNESDAY

OCTOBER 24

INTERIM MEETING

of the

RHODE ISLAND MEDICAL SOCIETY

***At the Library* — 3:30 P.M.**

At the Sheraton-Biltmore

6 P.M.

Massachusetts Memorial Hospitals — Health for the American People. A Symposium presented Monday, November 21, 1955. Centennial Celebration. Little, Brown & Co., Bost., 1956. Gift of the Hospitals.

M.D. Anderson Hospital and Tumor Institute — Research Report, 1955. Gift of the University of Texas.

New and Nonofficial Remedies Containing Descriptions of Drugs Evaluated by the Council on Pharmacy and Chemistry of the American Medical Association. J. B. Lippincott Co., Phil., 1956. 2 copies. Gift of the Association.

William Pepper, editor—Text-Book of the Theory and Practice of Medicine. Vol. I. Phil., 1893. From the Estate of H. G. Partridge, M.D.

Problems of the Mind in Later Life. A Symposium reprinted from *Geriatrics,* vol 11, 1956. Gift of the Wm. S. Merrell Company.

Rockefeller Institute for Medical Research — STUDIES. Vol. 151, 1956. Gift of the Institute.

State Department of Health of Connecticut — One Hundred and Sixth Registration Report, 1953. Hartford. Gift of the State of Connecticut.

Veterans Administration Technical Bulletins. Series 10. Vol. VIII, 1955. Wash., 1956. Gift of the U.S. Government.

CARDIOLOGY POSTGRADUATE COURSE

sponsored by

RHODE ISLAND CHAPTER of the AMERICAN ACADEMY OF GENERAL PRACTICE and THE POSTGRADUATE MEDICAL INSTITUTE

NURSES' AUDITORIUM, ST. JOSEPH'S HOSPITAL

Wednesdays, October 3, 10, 17, 24 — November 7, 14 (No session October 31) from 10:30 A.M. to 12:30 P.M.

PROGRAMS

MANAGEMENT OF CARDIAC EMERGENCIES
Egan Kattwinkel, M.D., and Edwin O. Wheeler, M.D. . . . . ***October 3***

NEW DEVELOPMENTS IN THE MANAGEMENT OF CONGESTIVE FAILURE
David Littman, M.D., and Morton Berk, M.D. . . . . ***October 10***

EVALUATION AND MANAGEMENT OF PERIPHERAL VASCULAR DISEASE
John B. McKittrick, M.D., and Charles W. Robertson, M.D. . . . . ***October 17***

THE PLACE OF SURGERY IN HEART DISEASE
Paul Zoll, M.D., and Allen Friedlich, Jr., M.D. . . . . ***October 24***

DIFFERENTIATION OF CARDIAC FROM NON-CARDIAC: SYMPTOMS AND SIGNS
Gordon S. Myers, M.D., and Harold D. Levine, M.D. . . . . ***November 7***

NEW DEVELOPMENTS IN THE TREATMENT OF CORONARY DISEASE
Joseph E. F. Riseman, M.D., and Elliot L. Sagall, M.D. . . . . ***November 14***

TELEVISION PROGRAMS OF THE WOMAN'S AUXILIARY

October 10, 1956

CLINICAL DISCUSSION OF A PATIENT'S SYMPTOMS FROM THE SPECIALISTS' VIEWPOINTS

Arnold Porter, M.D.; William J. H. Fischer, Jr., M.D.; Ernest K. Landsteiner, M.D.; Henry C. McDuff, M.D.

October 17, 1956

A NEW METHOD OF EARLY CANCER DETECTION

Thomas H. Murphy, M.D.; Herbert Fanger, M.D.; Y. S. Song, M.D.

October 24, 1956

THE DIFFERENCE BETWEEN THE DUTIES OF RESIDENTS, INTERNS AND ORDERLIES

John B. Lawlor, M.D.; J. Douglas Nesbitt, M.D.

October 31, 1956

THE FINDINGS OF A PATHOLOGIST

Gary P. Paparo, M.D.

November 7, 1956

STRABISMUS

H. Frederick Stephens, M.D.; Linus A. Sheehan, M.D.; Lee G. Sannella, M.D.

November 14, 1956

DIFFERENT TYPES OF ANESTHESIA AND WHY

Harry E. Darrah, M.D.

November 21, 1956

ALLERGY IN CHILDREN

Peter L. Mathieu, Jr., M.D.; Betty Burkhardt Mathieu, M.D.

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